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ASSESSMENT: CARE TUMAINI PROGRAM

Provides Home-Based Care for People Living with HIV/AIDS and Support for Orphans and Vulnerable Children

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ACRONYMS

AMREF	African Medical and Research Foundation
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community based organization
CDC	Centers for Disease Control
CDO	Community Development Officer
CMAC	Council Multisectoral AIDS Committee
CMO	Chief Medical Officer
COUNSENUTH	Center for Counseling, Nutrition and Health Care
COP	Chief of Party
CTC	Care and Treatment Center
DCOP	Deputy Chief of Party
DHMT	District Health Management Team
DMO	District Medical Officer
DSW	Department of Social Welfare
FBO	Faith based organization
FHI	Family Health International
GAF	Grants, Administration and Finance
GOT	Government of Tanzania
HBC	Home based care
HI	Heifer International
HST	Healthscope Tanzania
MOH	Ministry of Health
MUCHS	Muhimbili University College of Health Sciences
MVC	Most vulnerable children
NACP	National AIDS Control Program
NGO	Non government organization
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PASADA	Pastoral Activities and Services for People with AIDS in DSM
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
RFA	Regional Facilitating Agency
RMO	Regional Medical Officer
S&D	Stigma and discrimination
SHDEPHA+	Services, Health and Development for PHA Living Positively
SWO	Social Welfare Officer
TACAIDS	Tanzania Commission for AIDS
TMAP	Tanzania Multisectoral AIDS Program
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VSHP	Voluntary Sector Health Program

EXECUTIVE SUMMARY

Background

The USAID-funded CARE Tumaini program, which commenced in January 2004 and ends December 2005, provides home-based care (HBC) for people living with HIV/AIDS (PHA) and support for orphans and vulnerable children (OVC) in 5 regions of Tanzania through 23 grantees. The Tumaini program is implemented by an Alliance, which involves a partnership between six organizations: CARE Tanzania, the lead management agency; Center for Counseling, Health and Nutrition Care (Counsenuth); Family Health International (FHI), the lead technical agency; Healthscope Tanzania (HST); Heifer International (HI); and Muhimbili University College of Health Sciences (MUCHS).

The program has 7 key results: OVC have access to a package of health, educational and socio-economic support; PHA accessing quality care and treatment services; increased capacity of sub-grantees in supporting PHA/OVC; improved referral systems with local health facilities; increased number of communities with functioning mechanisms for OVC/PHA support; increased economic self-sufficiency for OVC/PHA; and reduced stigma and discrimination.

The main objectives of the Tumaini assessment were: to assess progress towards these key results; to review organizational issues, including program leadership, management, structure, staffing, procedures and practices; to review service issues, including the range, accessibility, availability and quality of services provided and linkages and referral systems; and to make recommendations to strengthen the Tumaini program and to inform the scope of a USAID-funded follow-on program. A team of two consultants and the Office of the US Global AIDS Coordinator HIV/AIDS Palliative Care Advisor conducted the assessment during 2-19 May 2005.

This Executive Summary highlights key findings and recommendations. Background to the program and the assessment is included in Section 1. Findings are discussed in more detail in Section 2. Recommendations to be implemented between now and the end of 2005 are provided in Section 3. Recommendations for the follow-on program are included in a separate document for USAID.

Findings

Achievements

- Tumaini supports national goals and is consistent with national policy. For example, Goal 8 of the National Multisectoral Framework is to increase the number of PHA who have access to a continuum of care and support from home and community to hospital levels, and Goal 9 is to reduce the adverse effects of HIV/AIDS on orphans. The program also supports one of three thematic areas in the MOH Health Sector HIV/AIDS Strategy 2003-2006 – care and support – which encompasses training, HBC, counseling, psychosocial support and palliative care, comprehensive management of opportunistic infections (OIs), increasing access to ART, nutrition and integrated HIV/AIDS/TB care.

- Tumaini has established good relations with government at national, regional and district levels and has taken care to follow national policies and guidelines. Valuable technical assistance has been provided to the Ministry of Health National AIDS Control Program (MOH NACP) to revise national HBC guidelines and training materials, develop nutrition guidelines, and support IEC on stigma

and discrimination, and the program has established good links with the Department of Social Welfare (DSW). Government stakeholders are kept informed about the program; quarterly reports are shared and government representatives are invited to Tumaini quarterly review meetings. There is strong government support for continuation of program activities beyond 2005.

- Tumaini PEPFAR targets for 2004 were exceeded and the program is on track to meet 2005 targets. Targets for 2004 were 4,500 PHA and 9,500 OVC; 2005 targets are 12,500 PHA and 25,000 OVC. By March 2005, Tumaini had reached 7,126 PHA and 12,620 OVC. Tumaini funding has enabled grantees to initiate new activities, for example, OVC and food-related IGA support, to reach additional clients, and to expand the range of services provided, for example, food distribution and other material support. The program has established the foundations for comprehensive care and support and referral networks, and offers the potential to develop useful models for scale up.

Challenges

- Tumaini is a complex program, with 6 partners and 23 grantees operating in 5 regions of Tanzania. The program design, in terms of the range of organizational inputs and interventions, was ambitious. A multisectoral approach to HBC is a new concept in Tanzania and many stakeholders take the view that the primary purpose of HBC is to promote ART adherence at the community level. IGA, food distribution and stigma reduction are challenging areas of activity. The timeframe for achieving results was also ambitious. The first 6 months of Tumaini were spent closing out VSHP, selecting grantees, recruiting staff, orienting grantees and preparing for training.

- The program is working in a challenging context, characterised by widespread poverty and food insecurity, and the demand for HIV/AIDS-related services is significantly greater than the capacity of the program and the grantees to respond. Establishing effective linkages between HBC programs and VCT, PMTCT and care and treatment clinics (CTCs) has been hindered by limited access to these services and slower than anticipated roll out of CTCs.

- Institutional weaknesses are also a challenge. There are no linkages between national bodies responsible for HBC and OVC and, until recently there was no policy framework for OVC support. District level capacity to coordinate HIV/AIDS activities is weak, and Council Multisectoral AIDS Committees (CMACs) have only recently been established. Shortages of health, social welfare and agriculture personnel have constrained efforts to ensure effective follow-up and supervision of program activities. The organizational and technical capacity of many NGOs and CBOs is also weak.

Organization and management

- The transition from VSHP to Tumaini was well managed, and the program was able to build on policies, procedures and grant making systems established under VSHP. Policies and procedures meet USAID requirements and guidelines, and the finance function is especially well developed.

- The Tumaini Alliance has helped to build good working relationships and networking between partners. All partners are positive about the potential benefits that an alliance of organizations with diverse expertise and experience

can bring to a multisectoral program. However, factors that have limited the effectiveness of the Alliance and the coherence of the Tumaini program include challenges related to management of alliances in general, the fact that the Alliance was established by USAID rather than by partners with common objectives, lack of attention to how the Alliance would work in practice, and inadequate leadership, consultation and communication.

- Differences in perceptions about roles and responsibilities between CARE Tanzania and USAID, and CARE Tanzania and FHI, have been problematic. The relationship between CARE Tumaini senior management and USAID has been difficult in recent months, due to USAID concerns about management decisions and competence. Inadequate attention was given to defining the administrative and technical functions of CARE Tanzania and FHI, and lack of clarity with regard to technical inputs and accountability has been a source of tension. Various factors have contributed to this. CARE Tanzania and FHI have a different understanding of what is meant by 'technical'; unlike the other Alliance partners, which have sub-contract agreements with CARE Tanzania, FHI has a separate contract with USAID; there is no MOU between CARE Tanzania and FHI; and neither CARE Tanzania nor the other partners have seen FHI's scope of work.

- Weaknesses in the program organizational structure reflect lack of clarity about roles and responsibilities and unresolved issues with regard to line management and technical accountability. Key issues include the separation of the technical team (the Alliance partner Technical Officers) from the main program staffing structure and lack of clear lines of communication and accountability between grantees, regional staff and the technical team. The technical team has received inadequate support from CARE Tanzania. Communication between the technical team and CARE Tanzania Tumaini staff has been poor, and decisions with technical implications have been taken without consulting the technical team.

- Staff turnover has been high. This appears to be due to poor recruitment practices, inadequate compensation, unclear role definition, and ineffective support and management, in addition to normal attrition. CARE Tanzania has now filled vacant positions and taken steps to improve staff terms and conditions. The transition to new senior management will need to be carefully managed and plans put in place to ensure staff retention. Job descriptions need to be revised, to clarify roles and responsibilities and line management and reporting arrangements. Plans to recruit Regional Technical Officers will not address weaknesses in technical backstopping to grantees and are not appropriate given the remaining program timeframe.

- The grant management system is comprehensive and ensures financial accountability on the part of grantees, although some find reporting requirements complex and time consuming. There have been delays in disbursement of funds to grantees – some have not yet received funds for 2005 – and this is attributed to delays in transferring funds from USAID to CARE Atlanta and from CARE Atlanta to CARE Tanzania, financial procedures, and difficulties experiencing by partners and grantees in meeting reporting requirements. Delayed disbursements have had an adverse effect on program implementation.

- Many of the organizational and management problems identified by the team as the same as those identified by the VSHP assessment – for example, programming that is budget and grant management driven rather than technically driven, problems with staff retention, delays in disbursements to grantees,

difficulties experienced by grantees in meeting financial reporting requirements, and poor technical support and organizational capacity building for grantees – indicating that lessons were not learned and recommendations were not addressed.

Interventions and services

- Tumaini established a clear process and criteria for selecting grantees. Despite this, some organizations selected had little or no experience in HBC and OVC, and limited capacity, and these grantees still require considerable organizational and technical inputs.

- While Tumaini has strengthened organizational capacity, through funding staff positions, management support has been limited to initial orientation workshops to ensure that grantees were able to submit appropriate proposals and budgets for funding and are able to meet financial and narrative reporting requirements. Limited attention has been paid to building strong sustainable organizations, including support to enable grantees to diversify their funding base. CARE Tanzania is the only donor for many of the smaller grantees and most grantees depend entirely on Tumaini to fund HBC and OVC support activities. Unless these organizations are supported through the follow-on program, activities initiated under Tumaini will not be sustained.

- Little attention has been paid to building the technical capacity of grantees to manage comprehensive HBC and OVC programs. There is no strategy to provide grantees with technical support and no clear mechanism for grantees to access technical advice or for Technical Officers to provide technical support to grantees or ensure the technical quality of implementation. There are no Technical Officers with expertise in practical nursing aspects of HBC and OVC support, and this is a serious weakness.

- The program has implemented an extensive HBC training program, which has improved volunteer motivation and the care they provide for PHA. The length, content and focus of training need to be revisited to ensure that it provides community volunteers with appropriate knowledge and practical skills. Consideration should be given to follow-up or refresher training to address gaps in volunteer knowledge and skills. The program has no strategy to ensure that grantees provide support to volunteers, to help them deal with problems or to prevent burnout, and to help retain trained volunteers.

- The extent to which volunteers are putting training into practice differs. Some are providing good quality comprehensive care and referring clients appropriately, while others are just conducting home visits and delivering commodities such as food. There is no minimum package of care or set of standards for volunteers. The ART adherence and clinical management aspects of the program remain weak. The program also needs to revisit the roles and responsibilities of volunteers and supervisors. In practice, supervisors often carry out volunteer roles in homes, and most of the tasks listed for supervisors are not supervisory and should be performed by volunteers.

- Supervision of volunteers and supervision of supervisors is critical to delivery of quality services. Lack of supervisory skills was identified as a major weakness, and a 5-day supervision skills training program was developed to address this. Despite clear criteria, some grantees selected inappropriately qualified staff for

supervisor training. The status of supervisors and the time they have available to supervise volunteers varies. Some do supervision in addition to an existing full-time job and receive a monthly allowance of TSh 30,000 in recognition of this, while others are paid as full-time Tumaini supervisors. Responsibility for supervising the supervisors is unclear. This needs to be anchored at district level, and the program should take steps to engage district health authorities in supervision of HBC programs. More attention also needs to be given to supervision of other aspects of care and support for PHA and support for OVC, through engagement with other sectors at district level.

- Problems with procurement of HBC kit supplies have been resolved, but volunteers and supervisors in some regions have not received the full contents. There is a lack of clarity about responsibility and the process for replenishing kits.

- The intention was for Tumaini-supported HBC programs to provide PHA with comprehensive care and support. In practice, programs have focused on clinical care and food distribution. Although the availability of the HBC kit contents has been inconsistent, the supervisor HBC kits have played a useful role, providing free drugs that clients would otherwise have to pay for. Not all PHA receive psychosocial and IGA support, referrals to other services, or support for stigma reduction. The program needs to ensure that grantees, as far as possible, provide the minimum intervention package for quality HBC and address the following gaps identified by the team: OI prophylaxis (especially routine provision of cotrimoxazole); basic nursing care; pain and symptom assessment and relief; end of life care; counseling clients on difficult issues (such as testing and disclosure and on prevention of sexual transmission of HIV); developing active referral networks; and support for clients on ART issues, such as side effects, adherence and developing simplified methods for ART clients and HBC volunteers to improve side effect management and adherence measures.

- Tumaini funds provision of a monthly food package to PHA. Food distribution is highly valued by clients, especially those taking ART. Food distribution is not targeted and its impact on PHA or OVC nutritional status is likely to be minimal, since the package is often shared with other family members. Despite technical inputs from Counsenuth, volunteers do not appear to provide households with nutrition counseling or encourage the use of nutritious indigenous foods.

- Through HI, Tumaini has provided food-related income generating support to 400 households. This has been challenging, due to limited grantee experience in food-related IGA and lack of mechanisms for follow-up support to households. Limited budgets and initial delays have restricted the number of beneficiaries. Food-related IGA support has focused on PHA households; few OVC households have benefited. The range of food-related IGA options has expanded as the program has evolved, but there is strong demand for a wider range of options and for access to micro-credit to support small businesses, especially in urban areas where keeping livestock and vegetable gardening is not feasible.

- MUCHS has provided useful inputs to orientation of Tumaini staff and grantees on stigma issues and to training of trainers of volunteers and supervisors. It is too early to judge the impact of these activities; an assessment is planned later in 2005. Where stigma is reported to have declined, grantees attribute this to a range of factors, including HBC volunteers, availability of ART, food distribution, and training of church leaders, rather than to program stigma reduction activities. The assessment should collect data about the factors that contribute to stigma

reduction. There has been limited involvement of PHA and PHA organizations in program efforts to reduce stigma and discrimination, and the issue of OVC stigmatization has received limited attention.

- Establishing effective referrals and linkages between HBC programs and VCT, PMTCT and CTC sites is a critical component of the program, but faces many challenges. While some grantees have established strong networks and effective referral systems, others need support to translate the referral guidelines into practice. District coordination of HBC and HIV/AIDS care and treatment services is often weak, resulting in lack of coordination between HBC service providers and lack of effective linkages and clear referral mechanisms between VCT, CTC and HBC services. Other barriers include: the limited availability of VCT and PMTCT services and slower than anticipated roll out of CTC sites; the current policy of not giving clients written HIV test results; the cost to clients of investigations required to access treatment, and the cost of transport, especially from rural areas; the lack of standard, recognized referral forms; and the lack of CTC staff with responsibility for referral and linkages to HBC programs.

- While all grantees report on activities to district health authorities, the extent to which grantees have built sustainable partnerships with local government varies. With the exception of the volunteers, there has been relatively little community involvement in the program, and community support for PHA and OVC generated by Tumaini has been limited.

- OVC support is the weakest aspect of the program. Tumaini has no clear technical package for OVC support. None of the Alliance partners has expertise and experience in OVC programming. Grantees have received no guidance or technical inputs on OVC support. Most have opted to provide material support for education and food; health care is not consistently provided by all grantees. There has been limited focus on improving the quality of life of children infected and affected by HIV/AIDS, including addressing OVC needs for psychosocial support, bereavement counseling, legal advice, vocational training, economic strengthening, HIV/AIDS prevention and treatment, and child protection.

Monitoring and evaluation

- Monitoring and evaluation has been given relatively low priority and does not appear to be integral to the program. The main emphasis has been on collecting quantitative data to measure progress towards PEPFAR targets. It is not clear how progress towards some results, for example, increases in grantee capacity and functioning community mechanisms or improvements in referral systems, will be measured. Collection of qualitative information, including client feedback, has been limited. Another challenge to measuring progress is the lack of baseline information. The survey conducted in September 2004 did not provide baseline data related to all 7 results or to PHA and OVC needs and priorities.

- HST involved all Alliance partners in developing the data collection system, and rolled out the monitoring system to grantees in the last quarter of 2004, providing additional training on the data collection tools and reporting system. Volunteers find completing the data reporting forms complex and HST is currently revising and simplifying these forms. Reporting is primarily ‘upward’, and there is no system for feedback to grantees, supervisors and volunteers, or communities.

- Tumaini has achieved some notable successes. Some grantees are developing interesting and innovative models. While the program plans to bring together all grantees in the third quarter of 2005 to share experience, there is no program strategy to document and disseminate lessons learned.

Summary of recommendations

The team recommends that the Alliance focus on achieving the following objectives between now and the end of 2005:

Improve management and coordination
- Revise program structure and reporting.
- Review organizational and staff roles and responsibilities.
- Establish effective oversight of the program and an effective working environment.
- Develop and implement an integrated program plan.
- Simplify and streamline financial reporting requirements and disbursements.

Consolidate training and supervision
- Address key gaps in supervisor and volunteer core skills.
- Clarify supervisor and volunteer roles and responsibilities.
- Establish and implement minimum standards.
- Strengthen supervision structures and district linkages.
- Provide support for volunteers.

Strengthen technical support and quality of services
- Establish effective planning and implementation of technical inputs, including the development, implementation and evaluation by the technical team of a joint technical strategy and plan to address key gaps in grantee organizational and technical capacity and service delivery.
- Provide adequate support to the technical team.
- Add expertise in HBC nursing care and OVC support to the technical team.
- Strengthen clinical and nursing care within HBC.
- Review feasibility of including cotrimoxazole prophylaxis for symptomatic PHA.
- Address shortfalls in HBC kits.
- Develop a package of minimum standards for OVC support.
- Develop a strategy for technical oversight and monitoring of the quality of grantee activities.

Strengthen referral linkages and systems
- Strengthen linkages between HBC programs, VCT, PMTCT and CTC sites.
- Assist grantees to establish networks and referral systems.
- Develop model networks in 5 districts that enable PHA and OVC to access a range of quality treatment, care and support services.

Assess impact
- Develop and monitor indicators for key program results.
- Establish a system for analysis and feedback of data collected.
- Conduct follow-up to assess the outcomes of food support, stigma reduction and food-related IGA activities.
- Identify and document experience, examples of effective models of care that provide PHA and OVC access to a range of quality treatment, care and support services, and lessons learned.

1. INTRODUCTION

Background

The CARE Tumaini program, which commenced in January 2004 and ends December 2005, provides home-based care (HBC) for people living with HIV/AIDS (PHA) and support for orphans and vulnerable children (OVC) in 5 regions of Tanzania through 23 grantees. These grantees include faith-based organizations (FBOs), non-government organizations (NGOs) and community-based organizations (CBOs). The program is funded by the US Government, through USAID under the President's Emergency Plan for AIDS Relief (PEPFAR).

Tumaini is a follow-on to the USAID-funded Voluntary Sector Health Program (VSHP), which was implemented by a Consortium of CARE Tanzania, Johns Hopkins University, and Healthscope Tanzania (HST) from July 2001 to December 2003. VSHP funded FBOs, NGOs and CBOs to support HIV/AIDS prevention and care, maternal and child health and family planning interventions at community level as well as to build partnerships between the public and voluntary sectors.

The Tumaini program is implemented by an Alliance, which involves a partnership between six organizations:

- CARE Tanzania is the lead management agency.
- Center for Counseling, Health and Nutrition Care (Counsenuth) is responsible for nutritional care and support inputs.
- Family Health International (FHI) is the lead technical agency.
- Healthscope Tanzania (HST) is responsible for monitoring and evaluation inputs.
- Heifer International (HI) is responsible for income generating activities (IGA) inputs.
- Muhimbili University College of Health Sciences (MUCHS) is responsible for stigma reduction inputs.

The original objectives of the Tumaini program were:

- To manage a grant system that provides funds to sub-grantees, alliances and for rapid response activities.
- To develop strategic alliances with organizations doing interventions in care and treatment services for PHA and OVC support.
- To promote partnership between Council Health Teams, civil society organizations and partners.
- To facilitate the continuum of care and support for PHA.

These objectives were revised in the first quarter of 2005:

- To increase access to and promote improved quality of comprehensive HBC services and OVC support for families affected by HIV/AIDS.
- To develop approaches in care delivery, which integrate essential components of medical, social, nutritional, psychological, economic, legal and other inputs to meet the needs of families living with HIV and its consequences.
- To build linkages and partnerships with relevant organizations, health facilities and local government structures at community and district level to ensure coordination in the delivery of care and support.
- To facilitate the delivery of care and support services across a continuum from home and community to facilities and programs and back.

- To build the capacity of local organizations, ranging from established missions and FBOs to new CBOs, to manage programs that strengthen well-being at household level by delivering the different components of a comprehensive HBC service.

The Tumaini program PEPFAR targets were to reach 4,500 PHA and 9,500 OVC in 2004 and 12,500 PHA and 25,000 OVC in 2005. The program has 7 key results:

- Result 1: OVC have access to a package of health, educational and socio-economic support.
- Result 2: PHA accessing quality care and treatment services.
- Result 3: Increased capacity of sub-grantees in supporting PHA/OVC.
- Result 4: Improved referral systems with local health facilities.
- Result 5: Increased number of communities with functioning mechanisms for OVC/PHA support.
- Result 6: Increased economic self-sufficiency for OVC/PHA.
- Result 7: Reduced stigma and discrimination.

The monitoring and reporting requirements on the above results includes collection of quantitative data to measure progress towards PEPFAR targets. Some Alliance partners have developed separate indicators to measure specific results, for example MUCHS and Result 7, but this was not done for other result areas.

Scope of work and methodology

The main objectives of the Tumaini assessment were:

- To review organizational issues, including program leadership, management, structure, staffing, procedures and practices.
- To review service issues, including the range, accessibility, availability and quality of services provided, linkages and referral systems.
- To make recommendations to strengthen the Tumaini program and to inform the scope of a USAID-funded follow-on program.

The assessment was conducted 2-19 May 2005 by a team of two consultants (Kathy Attawell and George Purvis), and the HIV/AIDS Palliative Care Advisor, Office of the US Global AIDS Coordinator (Julie Chitty). Findings and recommendations in this report are based on information gathered using the following methodology:

- Review of background and program documents.
- Briefing sessions with USAID and CARE Tanzania.
- Interviews with CARE, Counsenuth, FHI, HI, HST and MUCHS staff.
- Meetings in Dar es Salaam with representatives from the Tanzania Commission for AIDS (TACAIDS), Ministry of Health National AIDS Control Program (MOH NACP) and Department of Social Welfare (DSW).
- Meetings with other HBC stakeholders including CDC, AMREF and Pathfinder.
- Visits to 3 of the 5 regions covered by Tumaini – Arusha, Iringa and Mwanza – for meetings with Tumaini Regional Coordinators, regional and district government officials; group discussions with grantees, volunteers and supervisors, PHA clients and OVC; and site and home visits to observe grantee activities.
- Meeting with Regional Coordinator and grantees from Coast Region.

The scope of work is included in Annex 1. The assessment schedule and list of people met is included in Annex 2. Documents reviewed are listed in Annex 3.

2. FINDINGS

ORGANIZATION AND MANAGEMENT

Alliance effectiveness and leadership

The Tumaini Alliance has helped to build good working relationships and more effective networking between some of the partners. All partners are positive about the potential benefits that an alliance of organizations with diverse expertise and experience can bring to a multisectoral program. However, several factors have limited the effectiveness of the Alliance and the coherence of the Tumaini program. These include the way in which the Alliance was established, poor leadership, and inadequate communication.

Alliances are challenging to manage, even when organizations have chosen to work together to achieve a common vision and objectives, and many are not sustained. Factors common to successful alliances include: high levels of cooperation among partners; leveraging of capabilities; information sharing; trust; senior management support; establishing a negotiated set of ground rules and operating and management behavior; and clearly defined, open and effective communication channels.

The Tumaini Alliance was established by USAID, which determined the program components and selected the partners, a diverse range of organizations in terms of objectives, expertise and organizational culture. Prior to Tumaini, CARE Tanzania had had no links with HI or with FHI, which did not have a presence in Tanzania. The partners met for the first time in February 2004, after the Tumaini proposal had been submitted to USAID. There was limited consideration of how the Tumaini Alliance would work in practice, and insufficient time and attention were given to team building and to developing a shared understanding of program objectives, roles and responsibilities. In consequence, the way in which the Alliance operates has been a work in progress – in some instances modalities are still evolving – and this has contributed to some of the difficulties experienced.

Failure to ensure that the foundations for effective partnership were in place was due in part to pressure to start implementation as quickly as possible and in part to lack of leadership from CARE Tanzania. Effective leadership of alliances involves high levels of communication and consultation with partners, to develop trust and confidence and to achieve results. CARE Tanzania has delegated responsibility for management of the program and for coordinating the work of the Alliance partners to Tumaini senior management. Unfortunately Tumaini senior management has not always demonstrated a communicative and consultative leadership style – a number of critical program decisions have been made without reference to or discussion with either CARE Tanzania or the Alliance partners.

Tumaini also lacks an overall strategy that integrates the different components of the program. Although all partners contributed to developing the 2005 work plan, with the exception of training for volunteers and supervisors, each partner appears to be implementing a series of separate interventions in parallel rather than as part of a coherent program. Partners submit separate plans and budgets to CARE Tanzania and it is not clear that either CARE Tanzania or the Alliance have reviewed these plans to ensure that they address overall program objectives. For example, the Counsenuth plan for 2005 makes no mention of nutritional care and support for OVC and the HI plan makes no mention of links between food-related IGA and nutrition.

The need for regular communication between Alliance Directors is essential to the effectiveness of the Tumaini Alliance and of management and technical oversight. Alliance Directors meet at quarterly review meetings. These are formal meetings attended by USAID and government representatives, which do not provide a forum for Alliance Directors to discuss program plans and progress, or management and technical issues in any depth. The meeting observed by the team did not have an agenda, did not include reports from partners or review of future plans, and did not demonstrate active teamwork between Alliance partners at management level. Meetings of Alliance Directors need to be both more frequent and more effective.

The team also has some concerns about the efficiency of the program, in particular in terms of cost relative to numbers of PHA and OVC receiving services and the quality of services provided, and the ratio of staffing to grantees. It is not clear that CARE Tanzania or Alliance Directors discuss efficiency, cost or cost management issues.

Organizational roles and responsibilities

Lack of clarity, and differences in perceptions, about roles and responsibilities, in particular between CARE Tanzania and USAID and between CARE Tanzania and FHI, has been problematic.

CARE Tanzania had expectations that USAID would provide stronger leadership and direction, including inputs to establishing the Alliance. USAID had expectations that these functions would be carried out by CARE Tanzania. Both have interpreted differently the role of USAID, although this is clearly set out in Section 1.6 of the CA, which specifies USAID substantial involvement in implementation by CARE as follows:

- Approval of annual work plans and budgets.
- Approval of individuals proposed by CARE to fill positions designated as key personnel (initially only Chief of Party (COP); recently amended to include Deputy Chief of Party (DCOP) Programs).
- Approval of grant making process for awards under grants program.
- Approval of monitoring and evaluation plans.

The main mechanism for communication between CARE Tanzania and USAID is the quarterly review meeting. The relationship between USAID and Tumaini senior management has been challenging in recent months, due to USAID concerns about management decisions and competence. There is limited communication outside of the quarterly review meetings, which makes it difficult to address and resolve USAID and CARE Tanzania concerns. FHI, the lead technical agency for Tumaini, has a separate agreement with, and is funded directly by, USAID. FHI has regular communication with USAID outside of the quarterly review meetings and has, from the perspective of the assessment team, managed the relationship with USAID more effectively than CARE Tanzania.

The Tumaini Alliance was designed to draw on the different administrative and technical comparative advantages of CARE Tanzania and FHI. Inadequate attention was given to delineating the administrative and technical functions and responsibilities of these two partners. Despite efforts by CARE Tanzania and FHI to agree roles and responsibilities, lack of clarity with regard to technical inputs has been a source of considerable tension.

CARE Tanzania, the lead management agency, has primary responsibility for overall program implementation, including management, planning, liaison with and reporting to USAID and the GOT. CARE responsibilities also include grant and financial management, contracting with Alliance partners, with the exception of FHI, and with grantees, management of field staff and procurement, human resources and administrative functions.

The role of FHI, the lead technical agency, as set out in the RFA for technical assistance to the Emergency Plan, " focuses on HBC, strengthening linkages between community care providers and facilities proving ART; building family and community capacities to support OVC; and ensuring the quality of the technical components of service provision". It is expected that FHI will "provide leadership to Tumaini Alliance partners for all matters related to follow up of care and treatment; strengthening the capacities of voluntary agencies to deliver home-based and community-based care to PHA; strengthening the capacities of voluntary agencies working with OVC; and identifying innovative approaches to expand networks of service and appropriate referrals to strengthen the continuum of care in communities". Specific "activities include:

- Provide technical assistance to Tumaini HBC and OVC partners to ensure service provision in a continuum of care.
- Provide technical oversight and human resource development to Tumaini Regional Coordinators.
- Support technical training and human resource development among Tumaini grantees.
- Provide technical assistance to Tumaini partners to design, plan and implement programs to address OVC needs linked to HBC and clinical programs".

There appears to be a difference between CARE Tanzania and FHI in understanding of what is meant by 'technical' and of the distinction between technical oversight and technical management.

CARE Tanzania considers that it is accountable for overall delivery of the Tumaini program, including technical aspects. CARE considers that it has a 'technical' comparative advantage in the form of links with local government authorities, organizational capacity building for grantees and a regional staff structure and that its contribution goes beyond grant making. However, the view of the other partners is that established grant making, financial and administrative systems are the main comparative advantages that CARE Tanzania brings to Tumaini. CARE Tanzania does not have technical expertise in many of the core program components and has not used its considerable experience in community development including, for example, livelihoods and income generation, to inform the program. The organization's primary concern is with grantee financial reporting and accountability rather than with implementation and quality.

FHI considers itself accountable to USAID for technical oversight of the program and has pressed for a more direct role in implementation because of concerns about the competence of the former DCOP Programs and lack of technical leadership by CARE Tanzania. However, neither CARE Tanzania nor the other Alliance partners have seen the FHI scope of work as set out in the RFA. Some of the difficulties related to technical roles and responsibilities might have been avoided had this information been shared and discussed at the outset.

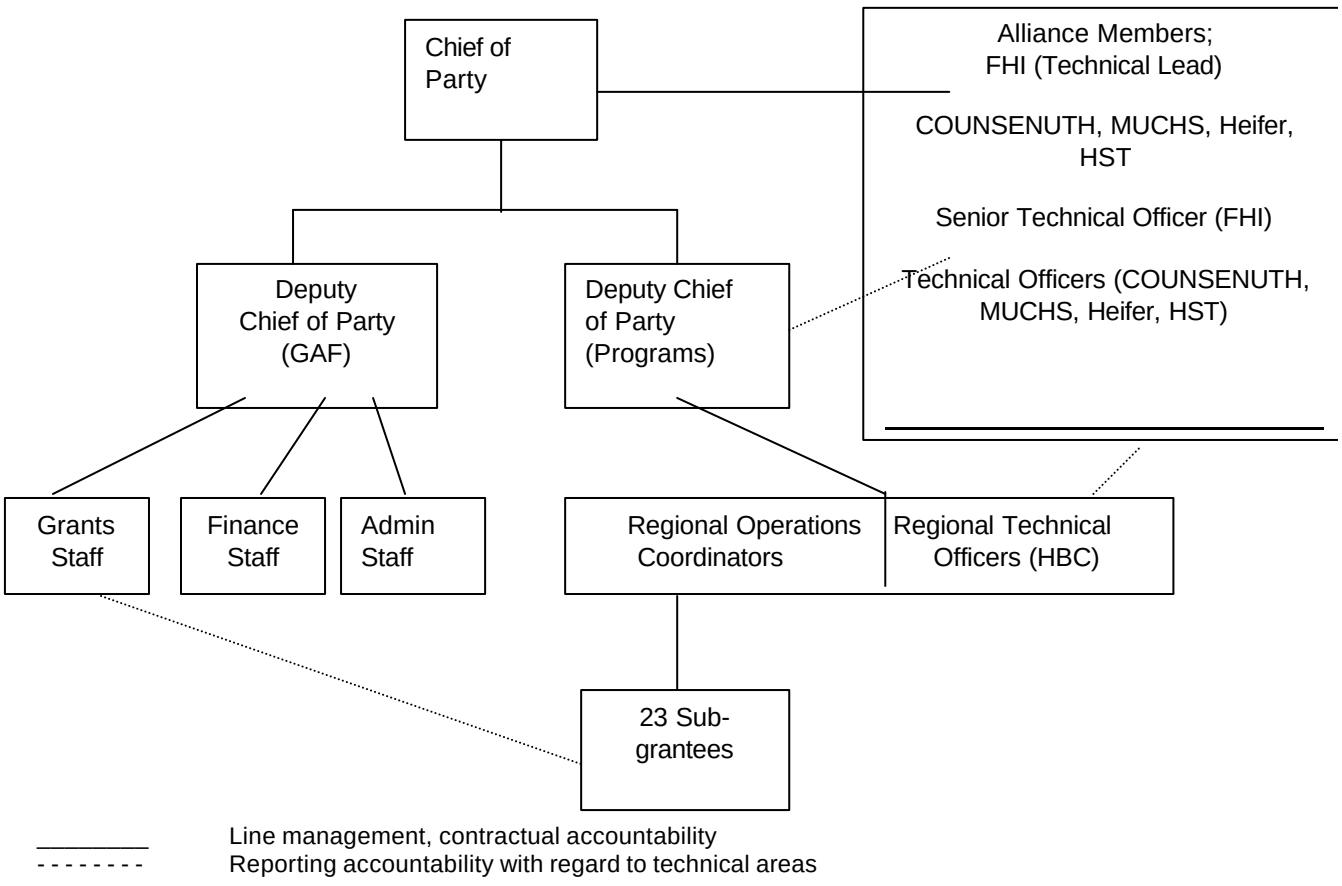
There is no MOU between CARE Tanzania and FHI, since FHI is funded separately by USAID not through Tumaini. FHI has therefore has a different relationship with CARE Tanzania to that of the other Alliance partners. This had made it more difficult to resolve problems, as while both are responsible for Tumaini, neither is responsible for the inputs of the other or can hold the other to account.

CARE Tanzania has sub-contract agreements with Counsenuth, HI, HST and MUCHS. However, there are no MOUs specifying partner roles, responsibilities and deliverables and there is no consistency in the job descriptions of the Technical Officers (TOs) seconded by each partner to the Tumaini program.

Structure and reporting

The Chief of Party (COP), Deputy Chiefs of Party (DCOP) for Programs and for Grants, Administration and Finance (GAF), other Tumaini headquarters staff and regional staff are CARE Tanzania employees. A TO is assigned from each of the Alliance partners to work full-time on Tumaini at the CARE office in Dar es Salaam and, with the exception of FHI, these TOs are hired through the CARE Tumaini grant.

Tumaini only recently developed an organogram outlining the relationships of the partners and reporting lines of program staff; an earlier version was developed but not distributed. Difficulties in reaching agreement on the organogram are indicative of different perceptions of the roles and responsibilities of each partner and of the way that they relate to program management, regional staff and grantees. These difficulties, and weaknesses in the organogram, also reflect unresolved issues with regard to line management versus technical accountability.



The organogram shows that the DCOP Programs and DCOP GAF report to the COP. The GAF staff report to the DCOP GAF, the regional staff to the DCOP Programs, and grantees to the Regional Operations Coordinators.

The TOs are separate from the main program structure and their lines of reporting and accountability are unclear, as is their relationship with the regional staff. The TOs report to the COP but they are coordinated on a day-to-day basis by the FHI Senior Technical Officer (STO), in recognition of FHI's role as the lead technical agency, and meet monthly.

The organogram also reflects a recent decision to split the role of Regional Coordinator into two posts: Regional Operations Coordinator (ROC) and Regional Technical Officer (RTO). At present, RCs are accountable to both CARE and FHI, according to whether the issue is managerial or technical, but report to the DCOP Programs. While this post has been vacant, the RCs have reported to the COP but, during this period, there has been no effective management or monitoring of the performance of the RCs and these staff have received little support.

The plan is for both the ROC and RTO, as CARE Tanzania employees, to report directly to the DCOP Programs, increasing his span of control from 5 to 10 staff, and giving him responsibility for administrative, financial and technical management in 5 regions. Regional staff are also supposed to be accountable to Alliance partners, primarily through the TOs, on technical issues. While reporting to the DCOP Programs, the RTO would be accountable to FHI, to ensure the technical integrity of this aspect of Tumaini. The ROCs would report to the DCOP Programs, and would be mainly accountable to CARE Tanzania. There are monthly RC meetings, which are attended by the TOs and CARE Tumaini GAF staff, but it is not clear how effective these meetings are and the team was unable to obtain meeting minutes.

The organogram does not make clear lines of reporting and accountability of grantees, with regard to GAF staff, RTOs and TOs.

In addition to the quarterly review meetings attended by Alliance Directors, the program has recently instituted a weekly meeting between the COP, DCOP Programs, DCOP GAF and the FHI STO to improve day-to day management and coordination and to ensure technical accountability. These meetings are unlikely to resolve problems related to technical accountability unless the underlying structural and line management issues are addressed. The Alliance needs to revise the organogram, line management and communication arrangements, to develop a more logical and streamlined system. The recommendations section of this report includes suggestions for a revised program structure, line management arrangements and meetings.

Technical inputs

The program encompasses a package of interventions, based on an assessment of HBC programs and needs in Tanzania conducted by FHI in October 2002. This assessment identified issues to be addressed including: gaps in nutrition support, nursing care at home and efforts to tackle stigma and discrimination; lack of integrated care and support programs; poor referral systems between community and facility levels and few links between civil society organizations and district structures; limited community involvement; and little support for OVC. These issues were taken into account in the Tumaini design and selection of partners, to ensure that the program provided a comprehensive continuum of care for PHA and OVC.

The technical aspects of Tumaini are addressed through two channels: the TOs and the other activities carried out by Alliance Partners. The technical team of TOs has worked together well, collaborating on training and covering other TO areas of responsibility during field visits to grantees. However, the team was allocated inadequate working space and communications and transport support by CARE Tanzania, reflecting the low priority given to technical inputs. Some TOs have therefore opted to work at their respective Alliance partner offices rather than at the Tumaini office.

Communication between the technical team and CARE Tanzania Tumaini staff has been poor. Proposals have been approved before the team has finalized technical review, new grantees have been selected and decisions have been made, including budget changes with technical implications, without consulting the technical team. Decisions made by CARE Tanzania appear to be budget driven rather than made on sound technical basis.

There is no CARE TO in the technical team and the team has no TOs to provide inputs on the practical nursing and clinical management aspects of HBC and OVC support. The lack of technical expertise in these two core areas of the program is a key weakness.

There is no clear mechanism for TOs to provide technical support to grantees. Grantees see their primary relationship as being with CARE Tanzania, which provides their funding, and the TOs have no authority to ensure that grantees implement technical advice provided. This has been a particular problem with some former VSHP grantees, making it difficult for the technical team and FHI to ensure the technical quality of grantee activities.

In practice, TOs spend considerable time supporting grantees on general organizational capacity building, grant management, budget and financial issues during field visits, rather than providing inputs related to their core areas of technical expertise. Reasons include regional staff vacancies at various times and the fact that most Regional Coordinators have a health background and are not able to provide organizational support to grantees. This is not an effective use of the skills and experience of the TOs.

Recruitment and retention

Staff turnover in the Tumaini program has been high. The program is about to hire a third COP and has recently hired a new DCOP Programs and DCOP GAF, and 4 of the 5 Regional Coordinators are relatively new. This poses challenges in terms of ensuring that all staff are familiar with program objectives and activities and establishing relationships with national, regional and district officials. Earlier efforts by FHI to orient national regional staff have had to be repeated.

High turnover is symptomatic of poor recruitment practices, unclear role definition, inadequate compensation, and ineffective support and management. Feedback to the team indicates that staff turnover at Tumaini is due to a combination of all of these factors, in addition to normal attrition. CARE Tanzania states that its terms and conditions compare favorably with those of other international NGOs and has taken steps to improve remuneration and benefits for regional staff. However, Tumaini is competing for qualified, experienced staff with donor agencies and other USAID-funded programs, which offer higher remuneration and better conditions.

Consideration should be given to measures to retain staff until the end of the program.

CARE Tanzania proposes to recruit an interim COP for 3 months while seeking a candidate to fill this post in the longer term. This approach should be reconsidered, since the current program is due to end December 2005. Failure until recently to recruit a suitable DCOP Programs has been major constraint to effective technical leadership and coordination of Tumaini. However, the new DOP Programs is well qualified and experienced.

Having three new staff in key positions provides an opportunity to address program weaknesses but also raises concerns about program continuity, and it will be important for CARE Tanzania and the Alliance partners to ensure that the transition is well managed.

Staff roles and responsibilities

The Alliance should revisit the job descriptions of senior management, TOs and regional staff to reflect changes in structure, reporting and accountability recommended by the assessment team.

In the COP job description, leadership and coordination of Tumaini comes after staff management. This should be the primary role of the COP. The job description allocates 25% of time to staff management. This should not be necessary with effective delegation to the DCOP Programs and DCOP GAF and if staff are given responsibility for taking decisions related to their area of expertise and responsibility. Reference to support for the Strategic Alliance Coordinator should be removed since this position no longer exists within the program structure. Relationships with other USG partners should be added to the key contacts section of the job description. The DCOP Programs job description does not make explicit the relationship with the TOs or with FHI, stating that the post holder will 'liaise very closely' with them. Suggested amendments to this job description are included in the recommendations section of this report. There are inconsistencies in the TO job descriptions. Some include provision of technical support to grantees and follow up, while others do not.

At regional level, the Tumaini program initially provided for one position, the Regional Coordinator (RC). The job description for this position includes responsibilities for regional management and coordination, networking and partnership building, financial and technical support and monitoring and supportive supervision for grantees. It is not feasible for one person to fulfill all these roles or to have the requisite skills and experience to do so. In practice, regional staff spend most of their time on coordination, grant management and financial issues, leaving them with little time for capacity building, technical back stopping or monitoring of activities.

In response to the concerns of partners, and of FHI in particular, about inadequate staffing at operational level and lack of capacity for technical backstopping of grantees, the RC job description has been split into two posts: Regional Operations Coordinator (ROC) and Regional Technical Officer (RTO). The main role of the RTO will be to provide support to grantees, supervisors and volunteers, including being the frontline source of advice regarding clinical referrals, and, if unable to provide this themselves, to refer grantees to the most appropriate source of support. The main functions of the ROC will relate to management and coordination.

An RTO has been recruited for Iringa Region and CARE Tanzania is in the process of recruiting RTOs for the other 4 regions. The intention is that existing RCs will either apply for RTO positions or will become the new ROCs.

The team has some concerns about these plans for regional staffing. The job descriptions do not clearly differentiate operational and technical tasks. The ROC job description includes, in addition to management, coordination and finance tasks, coordinating technical assistance for grantees and monitoring HBC and OVC activities. The RTO job description also includes tasks related to coordinating technical assistance for grantees and monitoring HBC and OVC activities. There has been limited consultation with existing regional staff. Current RCs are not aware that they will no longer have a technical role and are unsure whether the regional staff will work as a team or the RTO will report to the ROC.

While appreciating the need for technical backstopping at operational level, it is unclear why the program needs 2 staff in each region to manage 3-5 grantees. Recruitment of additional technical staff makes no sense. The existing RCs, with the exception of the RC in Iringa Region, have a technical – medical or health – rather than an operational background. In addition, recruitment of new staff at this point in the program makes no sense. It will be difficult to attract well-qualified and experienced candidates to positions with a 6-month contract and, even if suitable staff are recruited, it will take some time before they are able to provide useful inputs.

Furthermore, it is debatable whether the program will be able to recruit individuals who have the requisite knowledge and expertise to provide technical backstopping on all program components. For example, the RTO recruited in Iringa has a medical and family planning background, and has no experience of HBC, IGA, nutrition or OVC support. The same is likely to be true of RTOs recruited for other regions.

Policies and procedures

CARE Tanzania policies and procedures meet USAID requirements and guidelines. The finance function is especially well developed as staff long term experience with USAID programs, including financial reporting and control.

CARE Tanzania is responsible for procurement for the Tumaini program, using standard CARE procurement policies and procedures. There were delays in procurement of HBC kits for supervisors and volunteers. This was due to a combination of factors. It took until November 2004 for USAID Tanzania to obtain a waiver for kit contents from USAID. The supplier selected was unable to provide the quantities of items required initially and was slow to deliver. There were also concerns about the quality and possible contamination of some items, specifically paracetamol and ORT, which resulted in kit contents being recalled for checking.

CARE Tanzania took steps to address this, involving regional pharmacists in visual inspection and taking samples for analysis by the GOT chemist and FDA, and has also improved procurement procedures, commissioning a consultancy to revise protocols and establish a quality assurance system for procurement as well as to review local manufacturing capacity.

There are, however, still some problems with the HBC kits. In some regions, grantees, volunteers and supervisors reported to the team that they had not received the full kit contents. For example, in Mwanza Region, volunteers had not received gloves, soap or HBC kit bags; in Coast Region, grantees had received volunteer kits but not supervisor kits and some items were missing from volunteer kits. In some

regions, stocks received have been distributed to grantees; in others, supplies at the RC office have not yet been distributed. Storage of items in some regional offices needs to be addressed. Where stocks are not kept in a separate, secure store there is a risk of theft or contamination. The process of replenishing kit contents also needs to be addressed. Although this has been included in the budget, some regional staff and grantees are unsure whether CARE Tanzania or grantees are responsible for identifying requirements and procuring replacement supplies.

Grantee selection and grant management

Tumaini, specifically FHI, developed selection criteria, to enable the program to reduce the number of grantees from 230 under VSHP to 17 initially, and to identify a further 6 grantees in the first quarter of 2005. The selection criteria are clear and the program developed a step by step process for identifying potential grantees with experience in HBC and OVC support, including working with district government, mapping civil society organizations in the target districts, and conducting organizational systems audits and technical needs assessments.

Whether because the program did not follow the selection criteria and process, or because the choice of potential grantees is limited in some districts, some organizations selected had little or no experience in HBC or OVC support and limited capacity to manage funds or meet financial reporting requirements. In some districts, perception of the need to have a balanced portfolio of FBOs and CBOs resulted in the selection of inexperienced organizations as well as those with the potential to achieve significant coverage and to deliver quality services. Consequently, the 23 Tumaini grantees have widely differing experience and capacity, and some still require considerable organizational and technical inputs.

The grant management system developed under VSHP was already in place at CARE Tanzania. The system is comprehensive and ensures financial accountability on the part of grantees. The emphasis is on checking expenditure against agreed budgets, rather than ensuring that initial budgets are realistic and consistent across the program. For example, there is considerable variation between grantees in the proportion of the budget allocated to, and the costs of, staffing.

Grantees report monthly to CARE Tanzania. Reporting requirements are complex and time consuming for grantees. Consideration should be given to allowing some grantees to shift to quarterly reporting. The Rapid Funding Envelope (RFE), which focuses on well-established organizations with fewer capacity building needs than some Tumaini grantees, has been able to implement an effective reporting mechanism based on quarterly financial reports. Grantees reported that they had received limited support from CARE Tanzania and some compared CARE Tanzania's grant management approach unfavorably with that of the RFE, which is managed by Deloitte and Touche; there is a perception that Deloitte and Touche is approachable and helpful in contrast to CARE Tanzania.

There have been delays in disbursement of funds to grantees, especially between the end of 2004 and the start of 2005. Some grantees have not yet received funds for 2005. This has had an adverse effect on implementation. Some grantees have stopped food distribution to clients, which has had a negative effect on the credibility of the grantee organization and their volunteers in the community. Others have delayed payment of allowances to volunteers and supervisors. New grantees have been unable to pay for per diems and other expenses related to training for volunteers and supervisors. Delays in receiving funds also mean that grantees will have to implement planned activities in a more concentrated timeframe.

The problem is attributed to delays in transfer of funds from USAID to CARE Atlanta, from CARE Atlanta to CARE Tanzania, and from CARE Tanzania to grantees. USAID has not yet signed the extension for 2005 funding for Tumaini. CARE Atlanta will only release funding to CARE Tanzania when 70% of funds disbursed previously have been accounted for and the relevant financial reporting is complete. In practice, this has meant that delays in reporting by Alliance partners have affected the availability of funds for grantees. Financial procedures are based on CARE procedures, which in turn are based on USAID systems. It would be useful to review financial procedures to ascertain if the disbursement system could be streamlined. Delays in disbursements are also attributed to difficulties experienced by grantees in meeting reporting deadlines and providing inadequate supporting documents in financial reports. In addition, the budget process for 2005 did not start until the end of 2004 and grantee budgets were not agreed until well into 2005.

Funds are transferred directly from CARE Tanzania to grantees, but RCs spend a considerable amount of time responding to queries from grantees about transfer of funds and trying to expedite disbursement of funds, and responding to queries from headquarters and trying to assist grantees to meet reporting requirements. RCs are unable to explain to grantees why disbursements are delayed or when they can expect to receive funds, since headquarters does not communicate this information to them. Communication with grantees about budget cuts has also been poor, and there appears to be little or no consultation with grantees or RCs before budget decisions are made.

The recruitment of the new DCOP GAF provides an opportunity for the program to take a more supportive approach to grant management, and to review the roles and responsibilities of GAF and regional staff with regard to grantees. The GAF team has 4 full-time staff. The assessment team believes that GAF staff and grantees should communicate directly on queries related to transfer of funds and financial reports, rather than involving regional staff, and that GAF staff should take the lead in providing support on budget and financial issues to grantees.

INTERVENTIONS AND SERVICES

Organizational capacity building

Result 3: Increased capacity of sub-grantees in supporting PHA and OVC

Tumaini currently funds 23 grantees in 5 regions. This was expanded from 17 through the addition of 6 new grantees in 5 new districts in the first quarter of 2005. Pre-Tumaini, some grantees had no experience of HBC, while others had HBC programs but these were limited to home visits, providing psychosocial and spiritual support. Few were providing support to OVC.

The program has enabled grantees to initiate new activities, reach additional clients, and expand the range of services provided. Specific examples of new activities and services cited by grantees include material support for OVC and distribution of food to PHA. Some grantees report that Tumaini has strengthened organizational capacity, through funding of additional staff positions, and has improved their credibility with communities and with government, through provision of material support. The team noted that, in a few cases, Tumaini funding has substituted other funding for activities and staff positions, and did not necessarily increase the scale of HBC coverage.

Tumaini reports state that grantees receive comprehensive management support and technical advice. The intention is to build the capacity of grantees to scale up their activities in subsequent years. However, the assessment team saw limited evidence of a strategic approach to organizational capacity building.

Management support

Management support has focused on initial orientation workshops, to ensure that grantees were able to submit appropriate proposals and budgets for funding, and are able to meet financial and narrative reporting requirements. The RCs and TOs provide support for preparation of budgets and financial reports, but there has been no further organizational capacity for grantees. Some grantees expressed a need for additional training in budgeting and financial reporting. CARE Tanzania also reported to the team that some grantees do not have adequate systems in place and still require considerable support to produce accurate financial reports. This is despite the fact that CARE Tanzania has supported many grantees for several years, under VSHP as well as Tumaini, and raises questions about the effectiveness both of the grantee screening process and of CARE Tanzania capacity building for grantees.

CARE Tanzania is the only donor for many of the smaller grantees. Larger organizations, especially FBOs, are less dependent on CARE Tanzania. Most grantees depend entirely on Tumaini to fund HBC and OVC support activities, for example, Coast Region grantees reported 100% reliance on program funding. While a few have already starting to develop fundraising plans, most have not yet considered this and are unsure about what other donors exist or how to approach potential sources of funding.

Unless these organizations are supported through the follow-on program, activities initiated under Tumaini will not be sustained. Grantees that are providing material support, for example, food distribution and secondary school fees for orphans, are especially concerned about how they will be able to sustain this support. Ensuring that the significant investment in grantees, in particular the HBC training of volunteers and supervisors, is not wasted and that measures are in place to ensure continuity of services is critical.

While the team recognizes that such activities will continue to be dependent on donor funding, and anticipates that many of the Tumaini grantees will continue to receive support through the follow-on program, it is not healthy for organizations to be entirely dependent on one source of funding and 1-year funding cycles are a constraint to longer-term planning. Alliance partners need to identify grantees that merit continued support and CARE Tanzania needs to develop a strategy to support grantees to diversify their funding base.

Technical support

Technical support to grantees has focused mainly on HBC training for volunteers and supervisors. Grantee staff participated in this training, and Tumaini has provided grantees with orientation on issues such as stigma reduction. However, limited attention has been paid to building the technical capacity of grantee leadership to plan, manage, monitor and evaluate multisectoral and comprehensive HBC and OVC programs. For example, few grantees have expertise in areas such as ART adherence, nutrition, IGA, or orphan support. In practice, therefore, the range and quality of programming depends to a great extent on the pre-existing expertise and experience of individual grantees.

There is no strategy to provide grantees with technical support and advice. FHI and the TOs took the lead in conducting a grantee technical needs assessment in October 2004. However, the team saw no evidence of a plan or follow-up action to address needs identified by this assessment.

FHI and other Alliance partners have identified poor technical backstopping to grantees as a serious program weakness. This is due to lack of clarity about roles and responsibilities at central and regional level and lack of mechanisms for provision of technical support to grantees. FHI is responsible, according to the RFA for technical assistance to the Emergency Plan, for supporting technical training and human resource development among Tumaini grantees, but has had no direct relationship with grantees. CARE Tanzania does not view providing technical support to grantees as its responsibility. The RCs lack the time and skills to provide technical advice and do not play an effective role as gatekeepers to technical support from Alliance partners and TOs. As discussed earlier, the team has concerns about whether the proposed RTOs will have sufficient knowledge and expertise to provide technical advice related to all Tumaini program components. The role of the other Alliance partners is not clearly defined. The program has not made the best use of the TOs. There are no direct lines of communication between grantees and the technical team, and it is not clear how grantees can request or access technical advice. The program has not provided grantees with technical or resource materials to support their activities.

Training for volunteers and supervisors

The program has conducted broad, comprehensive training for grantee volunteers and supervisors. In 2004, 742 volunteers and supervisors participated in a 27-day HBC course, and Tumaini plans to train an additional 700 in 2005 using the revised 32-day national curriculum, which comprises:

Component	**Number of days**
Home-based care	19 (11 theory; 8 practical)
Nutrition	3
Stigma and discrimination	3
Communication skills	5
Monitoring and evaluation	1
Income generating activities	1

FHI identified lack of supervisory skills as a major weakness in the program, and developed and implemented a 5-day training that covers aspects of clinical, professional and managerial supervision. This training commenced in late 2004 and is continuing in 2005.

Grantees report that the training has empowered and increased the confidence of volunteers and supervisors. Volunteers told the team that the training had increased their motivation and enabled them to provide better care for PHA. Sessions that covered basic information about HIV/AIDS and stigma and discrimination had helped to reduce their fears, again enabling them to provide better care for PHA. Supervisors indicated that more training in supervision was required to enable them to supervise effectively.

The program and Alliance partners have been able to identify good trainers in each region. Good relationships with the MOH at regional and district levels have

facilitated agreement to release staff to conduct Tumaini training. In some instances it has been difficult to get government staff to provide training or to come for training as supervisors, since CARE Tanzania allowances and per diems are lower than government rates.

Despite training achievements to date, there are weaknesses in the training program and various issues should be considered in relation to any future training:

Consistency Training is inconsistent across the regions and from trainer to trainer. Some regions were not using the latest revised national curriculum and reduced the communication skills component from 5 days to 1 day. Furthermore, the content and quality of the training depends on the knowledge and skills of individual trainers.

Focus The training program is not well focused on the development of skills or competencies and does not target volunteers or supervisors appropriately. The course is designed for health workers not for community volunteers or volunteer supervisors, and primarily trains volunteers and supervisors to assess and refer rather than to provide practical nursing care and support or supervision of these tasks. The MOH plans to develop a 14-day course for community HBC volunteers that will place greater emphasis on practical skills, and this should be considered for future training of volunteers.

Content Weaknesses identified by trainers, grantees, supervisors and volunteers in some aspects of the training need to be addressed. Some reported to the team that the program had not responded to requests to address these weaknesses. Issues raised included inadequate evaluation of volunteer and supervisor competency, weak clinical management and ART adherence information, inadequate training on active referrals, and inaccurate information about palliative care. The content to be taught for each module in the curriculum needs to be defined to ensure consistency across trainers and trainings.

Length While it is reportedly not a problem for trainees to attend a 32-day course, for community volunteers, many of whom have had relatively limited education, this is a long time to be in the classroom and away from home. In addition, some perceive the training as an income generating activity, as trainees receive a substantial total per diem for 32 days.

Follow up There are no plans for follow-up or refresher training for volunteers and supervisors. The 32-day training covers a wide range of topics and a significant amount of information. With a one-off training, it is questionable whether volunteers and supervisors will be able to remember and put into practice everything they have learnt. Volunteers and supervisors need the opportunity to check their knowledge, sharpen their skills and to keep up to date. The program should consider collecting feedback from volunteers and supervisors to identify problems and areas where further training or support is required. For example, volunteers met by team indicated that additional training on communication and counseling skills would be helpful.

Materials The program has developed a reference guide for HBC providers. This is useful, clear and well produced, but contains much text and few pictures and may therefore be more appropriate for health workers at dispensary and health center level than for community volunteers. The program could consider producing a simple, user-friendly guide for volunteers. A good model is the Handbook for Community HBC Caregivers produced by the Ministry of Health and Social Welfare in Swaziland.

Delivery and quality of services

The quality of services provided by some grantees is good, but that of others is not of such a high standard. Better-established organizations, in particular FBOs, are most likely to be implementing integrated and comprehensive approaches. The extent to which volunteers are putting into practice what they have learned during training and the scope and quality of care also varies, depending on the grantee. Some are providing good quality comprehensive care and referring clients appropriately, while the role of others is limited to home visits and delivery of commodities such as food. There is no minimum package of care or set of standards for volunteers or supervisors. The program needs to establish these standards, to ensure consistent provision of quality care across grantees.

The program also needs to revisit the roles and responsibilities of volunteers and supervisors. Tasks have been defined on paper but, during field visits, the team observed that supervisors often carry out volunteer roles in homes, providing practical nursing care rather than supervising, and that the extent to which volunteers are providing care varies considerably. Most of the tasks listed for supervisors – for example, provide nutrition education and counseling services to clients and families, supervise client adherence to ART – are not supervision, and these tasks should be performed by volunteers. If volunteers are not expected to do these tasks, then there is little purpose in training them for 32 days.

Supervision of volunteers and supervision of supervisors is critical to delivery of quality services. FHI developed and implemented a 5-day supervision skills training program to address these weaknesses but there has been little follow up and evaluation or development of plans to supervise the supervisors.

Grantees are responsible for selection of supervisors. Some grantees, mainly those that provide health services, have selected supervisors from within their own staff. Others have selected supervisors from local health facilities – dispensaries or health centers. In some cases this has proved to be problematic, either because the grantee does not have a strong relationship with district health authorities or because health authorities are reluctant to release staff for training from health facilities that have only one nurse or clinical officer. Despite clear criteria developed by FHI, based on MOH guidelines, some grantees selected inappropriately qualified staff for supervisor training. In future, the program will check the suitability of staff selected before the come for training. There are also variations in the status of supervisors and the time they have available to supervise volunteers. Some conduct supervision in addition to an existing full-time job and receive a monthly allowance of TSh 30,000 in recognition of this, while others are paid as full-time Tumaini supervisors.

FHI has also highlighted the need to identify supervisors to supervise the supervisors, to monitor the quality of grantee implementation. At present, responsibility for this is unclear. Grantee supervisory tasks are included in the job descriptions of RTOs. FHI has also proposed establishing Regional Support Teams, which would have responsibility for supervision including regular supervisory site visits (as well as technical backstopping, assisting grantees to establish referral links, liaising with grantees on technical issues and linking these with RCs). Supervision should be anchored at district rather than regional level, and the program needs to take steps to engage district health authorities in supervision of HBC programs.

Supervision efforts have focused on clinical aspects of care for PHA. Little attention has been given to supervision of other aspects of care and support for PHA or for OVC. For example, there has been little effort to engage district social welfare or

agriculture authorities in supervision of OVC or IGA activities. While HBC supervisors receive training, bicycles and monthly allowances, there is no budget to provide similar support for supervisors from other sectors.

Sustainability

Caring for the chronically ill and supporting families that are experiencing severe poverty is stressful. Some but not all grantees organize regular meetings where volunteers can discuss difficulties and provide mutual support. The program has no strategy to ensure that grantees provide support to volunteers, to help them deal with problems or to prevent burnout, and to help retain trained volunteers.

Incentives are also important to retain volunteers. Volunteers have been given bicycles and receive a monthly allowance of TSh 10,000. The allowance helps volunteers to pay for household expenses and makes them feel valued. Some requested an increase in the allowance, as their HBC activities take up a significant amount of time and many are using their own resources to help the families they visit. This is a major challenge, and volunteers and supervisors expressed a strong desire to provide additional assistance for the families they work with.

Support for PHA

Result 2: PHA accessing quality care and treatment services

Home-based care

Definitions

- Home-based care is "the provision of care and support that endeavors to meet the nursing and psychosocial needs of persons with chronic illnesses and their family members in their home environment"[1].
- Palliative care is defined as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".[2] The terms palliative care and care of the dying (end of life care) are often confused. End of life care is only one component of palliative care because palliative care addresses need across the spectrum of care.
- The fundamental distinction between home-based care and palliative care is that home-based care is a delivery system adapted to the home environment and palliative care is a specific type of holistic care that is offered wherever it is applicable – in the home, community and in facilities, e.g. hospitals and hospices.

Tumaini has provided HBC and food support to a cumulative total of 7,127 PHA as of the March 2005. The target for 2004 was 4,500; 6,453 were reached by December 2004. FHI has provided important technical support to the NACP to revise the national guidelines for HBC services, HBC training course and trainers guide, and to produce a reference guide for HBC providers. Training of a cadre of trainers and of significant numbers of volunteers and supervisors has made an important contribution to strengthening HBC capacity in Tanzania.

[1] Family Health International, Comprehensive Care and Support Framework.
[2] World Health Organization definition of palliative care.

The intention was for Tumaini-supported HBC programs to provide PHA with comprehensive care and support including: psychosocial support; nutrition and food support; economic support through food-related IGA; treatment of OIs using the supervisor HBC kits; referral to other services including ART and palliative care; and support for stigma reduction.

In practice, aspects of clinical care and food support have been the main focus of HBC. Although availability of HBC kit components has been inconsistent, the supervisor HBC kits have played a useful role, providing free drugs that clients would otherwise have to pay for. Not all PHA have received psychosocial and IGA support, referrals to other services, or support for stigma reduction.

The emphasis on clinical care is not surprising, given the strong technical lead provided by FHI and the context in which the program is operating. While HBC is considered an essential element of comprehensive care in Tanzania and is higher on the agenda than before, many stakeholders see its primary purpose as promoting ART adherence at the community level and the concept of a multisectoral approach to HBC is relatively new in Tanzania. Grantees told the team that the government's recent focus on ART adherence risks minimizing the scope and importance of other HBC activities and creates pressure on HBC volunteers and supervisors to support an area in which they receive limited training and support.

HBC volunteers met by the team reported that they conduct the following activities:

Respite care (e.g. house keeping, washing clothes)	Daily basis for bedridden clients who are living on their own, as needed for clients with other household members.
Cooking	Daily basis for bedridden clients if food is available, as needed for clients with other household members.
Bathing client	Daily basis for bedridden clients who are living on their own and as needed for clients with other household members.
General assessment	Per visit but there is no checklist, monitoring tool for clients or guide for consistency.
Monitoring of medication	Inconsistent observation for clients on medication – HBC volunteers lack training in medication use.
Provision of paracetamol (Panadol) and aspirin (ASA)	As needed per opinion of client and HBC volunteer. Paracetamol and aspirin given for just about any symptom without proper assessment and follow up.
Communication (e.g. client education and psychosocial counseling)	As needed on basic information on HIV/AIDS, related topics e.g. HIV prevention, disclosure of status and nutrition. Counseling on difficult issues requires more attention. No clear guidelines or tools available for common, complex communication situations, e.g. bereavement counseling, succession planning.
Spiritual support and prayer	Much support is in the area of spiritual counseling and prayer. Clients and HBC volunteers often belong to different churches, so an interdenominational approach is most commonly used.
Referrals primarily to clinic and other care and support services	As needed, but no clear guidelines or resources available guide referrals. Clinic relationships vary according to clinic staff. HBC volunteers try to accompany client to clinic and at times use their own money to pay for consultation and/or medications.
Provision of traditional remedies	PHA use traditional remedies but little information is shared or known. Involvement of traditional healers to date has been on an informal, *ad hoc* basis.
Pain and symptom management	No access to pain or symptom medications or systematic way of assessing and managing pain and HIV/AIDS-related symptoms. Reliance on paracetamol, ASA and diclofenac without clear understanding of the difference.
Material support	HBC volunteers provide from the program and from their own resources.
Nutritional support	Monthly provision of food parcel but poorly targeted. No assessment or monitoring of nutritional status or monitoring of food intake, including asking client what they will eat that day and checking in the home to see if food is there.

The revised guidelines for HBC services set out the minimum intervention package for quality HBC which includes: physical care (health care; OI treatment; appropriate nursing care; ART monitoring for side effects and adherence; pain relief with NSAIDs and morphine; nutritional care and support; hygiene; exercise); emotional support; social support; spiritual support; legal support; economic support; and other related activities including reducing stigma and discrimination.

While it is difficult for the team to reach conclusions based on a few home visits, it appears that the scope and quality of care provided to clients varies from grantee to grantee. The program needs to ensure that grantees, as far as possible, provide the minimum intervention package for quality HBC and address the following gaps identified by the team. These include: OI prophylaxis (especially routine provision of cotrimoxazole), basic nursing care, pain and symptom assessment and relief, end of life care, counseling clients on difficult issues (such as testing, disclosure and prevention of sexual transmission of HIV), and support for clients on ART issues, such as side effects, adherence and developing simplified methods for ART clients and HBC volunteers to improve side effect management and adherence measures.

The team recognizes that implementing effective symptom control and pain management, and palliative care, is a challenge in Tanzania. Drug access is limited and pain management at health facilities and households relies heavily on use of aspirin and paracetamol. Use of paracetamol may mask underlying issues including allowing for appropriate investigation of emotional pain, mental illness or physical ailments such as neuropathic pain.[3] At the other end of the spectrum, the limited availability of morphine, especially morphine syrup, hinders effective management of severe pain especially near or at the end of life. While pain management, specifically access to opioids including morphine, is a priority for quality palliative care, comprehensive programs should address a wide range of needs including non-pharmaceutical pain management skills, management of chronic diarrhea, cough and skin disorders, oral health, and palliative care for infants and children.

Palliative care has been identified as an important component of comprehensive care and support, but little has been done to implement it. Palliative care is mentioned in the national care and treatment guidelines, but is defined as end of life care and does not address the full spectrum of holistic care and symptom and pain control needs of PHA. There are no palliative care policies or guidelines. Palliative care pre-service nursing training is limited, and community level training is minimally provided through the national HBC training curriculum.

With regard to prevention, it was reported to the team that condoms are not available or affordable in many rural districts. Consideration should be given to distribution of condoms by volunteers.

Comprehensive care for people with HIV also includes STI, TB and OI management. It was not possible to explore these aspects of clinical care, but several stakeholders expressed concern about poor linkages with TB programs and lack of information, training and drug supplies to support effective OI management at both the facility and community level.

Finally, the issue of client selection for HBC support should be reviewed with grantees. The original intent was to provide HBC for the chronically ill and while most grantees are taking this approach, a few are only providing support to those who

[3] The heavy reliance on aspirin increases the risk of gastric irritation (especially for people who are unable to eat). Misuse of paracetamol (panado) can lead to liver failure.

have been tested for HIV and have received a positive test result. This excludes from support those who are chronically ill, including PHA, who do not have access to VCT or have not come forward for testing for whatever reason.

Consideration also needs to be given to provision of care and referrals for people who are HIV positive but who are not chronically ill, including nutrition and hygiene counseling, cotrimoxazole prophylaxis, treatment for OIs and other measures to maintain health.

Food distribution

Tumaini funds provision of a monthly food package to PHA. Grantees are responsible for procurement, and the package variously includes flour, legumes, peanut butter, cooking oil, and sugar. In addition, grantees have a budget for volunteers to purchase vegetables and fruit for the PHA they visit. Food distribution is highly valued by clients, especially those taking ART. There is a widely held perception that PHA need food to be able to take ARVs and provision of food may play an important role in treatment adherence.

Counsenuth developed criteria for selection of food beneficiaries, based on assessing needs and requirements, and designed the food package. However, grantees appear to provide the food package to all PHA enrolled in their HBC programs and it is not clear how targeted distribution is. The food package is intended to supplement the diet of a PHA to improve their nutritional status but, given food insecurity in many poor households, is often shared with other family members. The impact on nutritional status of PHA is therefore likely to be minimal. Food procurement represents a substantial part of the overall Tumaini and grantee budgets, and it will be important to ensure that it is having the desired impact.

Counsenuth has also provided quality technical inputs to the nutrition component of volunteer and supervisor training and has published useful nutrition guidelines and other materials. Efforts have been made to orient grantees and volunteers to encourage households to use nutritious local and indigenous foods. However, it is not clear to what extent volunteers are putting this into practice, and the team saw limited evidence of provision of nutrition education and counseling to PHA and OVC households. Volunteers do not have simple tools or job aids to help them do this, and those met by the team did not identify nutrition counseling as one of their roles.

There are limited links between nutrition support and food-related IGA at the household level. Counsenuth and HI acknowledge that they need to work together more closely and to encourage greater integration by grantees. Not all households receiving food have received food-related IGA support or training. If they are not to remain dependent on food distribution, the program needs to step up efforts to assist these households to generate food-related income.

Income generating activities

Result 6: Increased economic self sufficiency for PHA/OVC

Tumaini, through HI, has provided food-related income generating support to 400 households. Limited budgets and initial delays have restricted the number of beneficiaries. Food-related IGA support has mainly been provided to PHA households; few OVC households have benefited.

The approach has evolved during program implementation. In 2004, IGA support focused on provision of dairy goats and vegetable seeds to beneficiaries, who also received training in goat management, bio-intensive agriculture and rainwater harvesting. In 2005, the range of options was expanded to include other livestock, such as poultry, in response to feedback from grantees and clients. However, there was strong demand from clients met by the team for a wider range of IGA options and for access to micro-credit to support small businesses, especially in urban areas where keeping livestock and vegetable gardening are not feasible.

During 2004, HI was responsible for purchasing livestock and seeds. In 2005, grantees received funds to purchase livestock and seeds directly, with HI assisting with links to suppliers. This has been challenging, since many grantees have no experience in buying or transporting livestock, and HI has had to provide additional support for procurement and delivery.

Grantees select the households to receive IGA support. There are concerns about the selection process, as some households find it difficult to care for the goats or to implement the training they have received in vegetable gardening, especially when PHA become sick. It will be important to ensure that grantees have the skills to assess household capacity to manage food-related IGA.

There have also been other challenges related to this program component. In some regions insufficient male goats were procured, so there have been delays in breeding and milk production and households have yet to see any nutritional and income benefits. Grantees did not budget for veterinary care for livestock. Agricultural institutions contracted to train beneficiaries in some regions provided shorter training than the HI recommended 12 days. Grantees are supposed to establish revolving funds following HI guidelines, but most have yet to do this, and there is some confusion about whether USAID rules on revolving funds allow this.

Households have received limited follow-up support. Grantees lack expertise in food-related IGA and are unable to provide support to households; training of volunteers and supervisors did not equip them for this role; and Tumaini regional staff also lack expertise in food-related IGA. It is assumed that district agriculture and livestock staff will provide follow-up support and supervision. Although HI has made efforts to link grantees with the government system, the program has made no provision for training, transport or allowances for district agriculture staff.

The intention was that food-related IGA support would both improve nutrition, of PHA and of the household, and generate income, from the sale of surplus goat milk and kids. It is not yet clear whether goats will produce sufficient surplus milk to sell or how rural households are expected to market the milk. The program should assess the impact of this activity on nutritional status and household income.

Reduced stigma and discrimination

Result 7: Reduced stigma and discrimination

MUCHS has provided useful inputs to orientation of Tumaini staff and grantees on stigma and discrimination issues and to training of trainers of volunteers and supervisors, and plans to train community leaders and to develop checklists to measure the impact of community stigma reduction activities. MUCHS is also developing simple indicators that volunteers can use to monitor stigma and stigma reduction. It would be useful if volunteers were also provided with simple practical

tools or job aids that they can use in counseling around stigma. It is too early to judge the impact of these activities – an assessment is planned later in 2005.

The team has some questions about the extent to which stigma reduction activities are integrated into the activities of grantees and volunteers. Where stigma is reported to have declined, grantees attribute this to a range of factors rather than to program stigma reduction activities. For example, Selian Hospital suggests that stigma reduction at household level may be due to the HBC volunteers, food support, increased access to services and ART in particular, training of pastors or the fact that almost every household is affected in some way, but is unsure which of these factors are most significant. The assessment design should ensure that it provides data about the factors that contribute to stigma reduction.

There has been limited involvement of PHA, and of PHA organizations, in program efforts to reduce stigma and discrimination. The perception that PHA cannot receive support from HBC programs if they are HBC volunteers has discouraged PHA from volunteering. This is a pity, as active involvement would help to address fear and stigma associated with HIV/AIDS and PHA could bring valuable insights and experience to the volunteer role. PHA who are well enough to work as volunteers should still be able to access services such as prophylaxis for OI. Stigma reduction efforts have also paid little attention to stigmatization of OVC, despite some evidence that OVC often experience stigma and discrimination in community, health care and educational settings.

Referrals and network model

Result 4: Improved referral systems with local health facilities

Tumaini selected districts based on the availability of health facilities providing care, treatment and support, specifically proposed sites for CTCs – so that PHA would have access to a continuum of care. Establishing effective referrals and linkages between HBC programs and these facilities is a critical component of the program, but faces many challenges. Coordination of HBC and HIV/AIDS care and treatment services is weak in many districts, resulting in lack of coordination between HBC service providers and lack of effective linkages and clear referral mechanisms between VCT, CTC and HBC services.

The 2005 work plan states that grantees will be assisted in refining existing referral systems to eliminate barriers to accessing health services; building linkages with facilities providing HIV care and treatment; and facilitating district level meetings at least every quarter. Regional Coordinators would also be responsible for compiling district inventories of organizations providing services. The program has taken steps to address some but not all of these issues.

FHI has developed useful referral guidelines for resource-limited settings but these guidelines have primarily remained in regional offices and have not been used to develop effective referral systems. Grantees need support to translate the guidelines into practice and assistance to develop a referral relationship with nearby facilities. The extent of referral and networking is influenced by the initiative and capacity of individual grantees rather than by inputs from the Tumaini program.

Grantees in Arusha and Mwanza regions have established strong links with other NGOs and government service providers and effective referral systems. For example, in Arusha, Selian Hospital CTC has clients referred from the Selian and

Pathfinder HBC programs and from other sites including government PMTCT sites and the UHAI VCT center. The Archdiocese of Mwanza has established effective linkages at its rural Bukumbi and urban Nyakato program sites: the majority of clients at the CTC at Bukumbi Hospital have been referred by Bukumbi HBC program volunteers, and the Nyakato AIDS Outreach Program has links with providers of legal advice, youth and PHA clubs, religious and community leaders, VCT centers, Nyakato health center and dispensary and the Sekou Toure regional hospital. More than 40% of clients attending Bugando Medical Center and Sekou Toure Hospital CTCs are referred by Tumaini grantees.

In contrast, fewer referrals are made by grantees in Iringa Region. The CTC at Iringa Regional Hospital has enrolled 341 patients since October 2004. Of the 109 who have been started on ART, only 2 were referred by the Alpha Dancing Group and only 9 by the Allamano Center. Most clients at the CTC are self-referrals or have been referred from other organizations, including other departments of the Regional Hospital, government health facilities and PMTCT sites, the Angaza VCT center, and the AMREF and CUAMM HBC programs.

Referral from the Iringa Regional Hospital CTC to Tumaini grantee HBC programs has also been limited, despite efforts by the CTC site coordinator to design a form for referrals between CTC and HBC service providers and regular meetings with HBC partners including Tumaini grantees.

In some Tumaini regions, referrals have been constrained by the slower than anticipated roll out of CTC sites. In Coast Region, there is no CTC, and grantees have to refer clients to Muhimbili Hospital or PASADA in Dar es Salaam. Both of these centers are oversubscribed and are unable to take on new clients.

Lack of access to VCT and PMTCT services is also a constraint, especially in rural districts. VCT is an important entry point for care and treatment, and Tumaini needs to strengthen links between HBC programs and VCT centers. There are plans to improve access to these services. The GOT aims to establish 6 VCT sites in each district. AMREF is supporting expansion of VCT at dispensaries and through mobile services, and NACP and CDC are collaborating on pilot VCT outreach in 5 districts in Mwanza Region through TANESA. Similarly, CDC is working with the MOH to expand PMTCT sites. It will be important for Tumaini and the follow-on program to establish links with these initiatives and facilities.

Other barriers to effective referral by grantees include limited grantee knowledge and awareness, including of the array of care and treatment services available at CTCs for PHA, cost and lack of transport. Some grantees, and their volunteers, are poorly informed about CTCs and told the team that they would increase their efforts to refer clients to CTCs if they received OI prophylais and basic clinical care. While CTCs provide ART and other treatment for PHA free of charge, clients have to pay for investigations before they can access treatment, and most cannot afford this. Some grantees do refer clients to VCT, PMTCT and CTC sites but lack of transport is a significant problem in rural areas, preventing clients from accessing services, and grantees do not have adequate budgets for transport. For example, in Mwanza, the team was told that most PHA cannot afford to pay for transport to get to Bugando Hospital for a CD4 test, which is necessary to access treatment, while others were too sick to travel.

Weaknesses in CTC staffing, lack of standard forms, and policy on written HIV test results are also key challenges. The original design for staffing of the CTCs included a nurse who would act as a HBC focal point but this post was eliminated in light of

budget and staff constraints. This means that there is no one with responsibility for referral and linkages between CTCs and HBC programs or for client follow-up.

Different grantees and sites are using different forms and there is no standard approach. Referral forms used by some grantees are not recognized by government facilities, so clients referred from HBC programs are turned away. Selian Hospital reports that they have worked with the MOH to develop simple referral forms. The program should review these to see if they can be used by all grantees.

The current policy of not giving clients written HIV test results, which the MOH is in the process of reviewing, means that repeat testing is required if clients are referred to a health facility for PMTCT, ART and other care and treatment. This is not only a waste of resources, but it may also deter some clients from following up on referrals.

Community support structures

Result 5: Increased number of communities with functioning mechanisms for PHA/OVC support

The 2005 work plan states that Tumaini will assist grantees to build sustainable partnerships with local government. This was one of the strengths of VSHP, but it is not clear that the Tumaini program has built on the partnerships established under VSHP. All grantees report on their activities to the District or Municipal Medical Officer and, for example, grantee plans are incorporated into the Mwanza City Health Department comprehensive plan.

The work plan also states that Tumaini will assist grantees to introduce activities at the community level, to enhance community involvement and promote linkages between communities, local government committees such as CMACs, and other HIV/AIDS activities. It was difficult for the team to assess progress in this area of activity, except on the basis of feedback from grantees.

Some grantees consulted communities and clients prior to planning and implementing activities, but others have carried out activities with limited reference to the community. In most cases, the only involvement of the community has been in selection of volunteers. Grantees themselves highlighted the need to improve community involvement and consultation, to ensure that services respond to priority needs. There are a few anecdotal reports of community support for PHA and OVC households, for example, assisting with construction of pens for diary goats, but Tumaini appears to have generated limited community response. The program has not defined responsibility for mobilizing community support for PHA and OVC. Community mobilization is not specified as the role of grantees or volunteers, and volunteer and supervisor training does not include community awareness raising and mobilization skills. In some communities, PHA reported to the team that the community had stopped helping them, because they see that they are receiving visits from volunteers, as well as commodities such as food. This needs to be carefully monitored by the program and grantees, to ensure that external support does not undermine community responses.

Where there has been a supportive community response, this has been initiated by FBOs, rather than by Tumaini. For example, the ELCT in Arusha has started the Every Church a Caring Church program to encourage congregations to support PHA, OVC and HIV/AIDS affected households.

Support for OVC

Result 1: OVC have access to a package of health, educational and socio-economic support

The Tumaini program has exceeded its 2004 target for OVC support. The target was 9,500 OVC and, as of the end of December 2004, 10,504 OVC were being provided with or referred for at least one of the following: school fees; school supplies; school uniforms; counseling; nutritional support; medical care; treated bed nets; legal assistance; and food-based IGA. The target for 2005 is 25,000; the cumulative number of OVC reached by March 2005 was 12,620. With sufficient resources, it should be feasible to reach this target, since all grantees report that the number of OVC requiring support significantly outstrips their capacity to provide services.

However, OVC support is the weakest aspect of the Tumaini program. This is due in part to weaknesses in the wider policy and institutional context and in part to weaknesses in the program. There is limited data on the extent of the problem and coverage of OVC support, although a data management system is being established to track service providers and children reached with services. The National Plan of Action has only recently been finalized. Training for the CMACs, responsible for coordinating the district response, does not cover OVC issues. The DSW is in the process of identifying OVC focal points at district level, but is hampered by a lack of human and financial resources for welfare support, referrals and supervision.

Tumaini has no clear technical package for OVC support and none of the Alliance partners has expertise and experience in OVC programming. The training, and roles and responsibilities, of volunteers and supervisors emphasize HBC and few have the skills to address the needs of OVC. Their ability to provide care and support for children, and to identify children who need HIV-related health care is sometimes compromised by the difficulties of communicating about HIV with family members who do not know or have not acknowledged their status. Most grantee HBC programs provide services that focus on the chronically ill individual adult, rather than a family-centered response. Training needs to emphasize that HIV/AIDS affects the whole family and that OVC issues are an important component of HBC for PHA, since parents are concerned about their children's future.

Grantees have received no guidance or technical inputs on OVC support. Most have opted to provide material support, mainly school uniforms, bags, exercise books and, in some cases, payment of secondary school fees, and there has been limited focus on improving the quality of life of children infected and affected by HIV/AIDS.

With some exceptions – for example, the Allamano Center in Iringa, which provides health care, counseling on vocational training, and information and referral on legal issues, and the Selian Hospital in Arusha, which offers nutritional, medical, educational, psychosocial and counseling support, and encourages church members to provide care and support for children affected by HIV/AIDS – few grantees are providing psychosocial support, bereavement counseling, legal advice or vocational training. Health care is not consistently provided by all grantees. OVC households appear to receive the same monthly package of supplementary food as PHA, and this is not linked to their specific nutritional needs. The program does not address other important OVC needs including economic strengthening, HIV/AIDS prevention and treatment, housing and child protection.

MONITORING AND EVALUATION

Program M&E

Monitoring and evaluation (M&E) aspects of the program have been given relatively low priority by CARE Tumaini management. There is a widely held perception that M&E is viewed as a separate activity that is the responsibility of HST rather than as integral to the program.

The main emphasis has been on collecting quantitative data to measure progress towards PEPFAR targets. While achievement of Results 1, 2 and 6 will be measured to some extent through routine data collection and grantee reporting, and MUCHS is developing separate indicators to measure Result 7, the program lacks indicators to assess progress towards Results 3, 4 and 5; it is not clear how increases in grantee capacity and functioning community mechanisms or improvements in referral systems will be measured.

Result 1: OVC have access to a package of health, educational and socio-economic support
Result 2: PHA accessing quality care and treatment services
Result 3: Increased capacity of sub-grantees in supporting PHA/OVC
Result 4: Improved referral systems with local health facilities
Result 5: Increased number of communities with functioning mechanisms for OVC/PHA support
Result 6: Increased economic self-sufficiency for OVC/PHA
Result 7: Reduced stigma and discrimination

Collection of qualitative information, with the exception of some case studies, and of client feedback has been limited. Without client feedback, for example, it will be difficult to demonstrate whether or not training has resulted in improvements in the quality of care provided to PHA or whether IGA support has increased economic self-sufficiency for PHA and OVC.

Another challenge to measuring progress is the lack of sound baseline information. HST conducted a survey, which collected information from 17 grantees about services provided and numbers of PHA and OVC reached with these services. The survey was conducted in September 2004, after the program commenced, so did not provide information about the situation at the start. The survey was also limited in scope, neither providing baseline information related to all 7 results nor collecting data from PHA and OVC about their needs and priorities. In addition, the findings do not appear to have been used to inform or revise program activities. For example, the survey identified weaknesses in nursing care, community support, IGA and OVC technical support, but these issues have not been addressed.

Data collection, analysis and feedback

HST took a participatory approach to developing the data collection system, which involved all Alliance partners. The HST TO provided inputs to orientation and training on monitoring and evaluation, and data collection, for grantees and volunteers. The monitoring system was rolled out to all grantees during the last quarter of 2004; HST provided additional training on the data collection tools and reporting system. Data collection tools include PHA and OVC registers, visiting record books and reporting forms for home visits, and program monitoring forms for PHA and OVC.

Volunteers find completing the reporting forms complex as well as time consuming, as forms have to be written in triplicate, and some are unclear about the purpose of the exercise. In some regions, volunteers reported to the team that they had run out of forms. HST is currently revising and simplifying the data collection forms. The revised forms should be compared with reporting formats used by some grantees – for example, Selian hospital has a simple checklist form that volunteers just need to tick – and field tested with volunteers before they are finalized.

Reporting is primarily 'upward'. Forms completed by volunteers are collated by the grantee. Grantees with limited capacity find this process challenging. Reports from grantees are then collated by Regional Coordinators and sent to CARE headquarters, where an HST data entry clerk enters the data into a program database established by the HST TO. There is no system in place for feedback of information to grantees, supervisors and volunteers, or communities. Feedback to grantees focuses on queries about financial reports.

Neither the program nor the grantees appear to use the information that they collect to review progress, plan activities or revise their approach. Grantees have limited understanding of program objectives and results, and of how their activities contribute to the bigger picture.

Lesson learning and documenting experience

The program could have done more at the outset to draw on good practice and experience outside Tanzania and to apply lessons learned about effective approaches to provision of HBC and support for OVC.

Tumaini has achieved some notable successes and some grantees are developing interesting and innovative models. Grantees in each region meet regularly to discuss program activities and find this useful, and the program plans to bring together all grantees in the third quarter of 2005 to share experience.

However, there is no program strategy to document experience, including identifying grantees implementing comprehensive quality services, and to capture and disseminate lessons learned. The identification and documentation of good practice could contribute to national efforts to scale up effective approaches to HBC and OVC support.

3. RECOMMENDATIONS

Recommendations for the Alliance

In view of the remaining program timeframe and the need to establish a sound foundation for a follow-on program, the team recommends that the Alliance focus on achieving five key objectives between now and the end of 2005: improve management and coordination; consolidate training and supervision; strengthen technical support and quality of services; strengthen referral linkage and systems; and assess impact.

Specific recommendations and responsibility for ensuring that these are taken forward are as follows:

Organization and management

- Organize a facilitated 1-2 day Alliance workshop to: 1) consider the assessment findings and develop an action plan for implementing the recommendations; 2) revisit and clarify partner roles and responsibilities; 3) agree revised organogram and staff job descriptions; 4) review program communication, decision making authority and line management issues; 5) establish agreed program priorities to end of December 2005, develop a joint action plan and identify responsibility for delivery. (*CARE Tanzania and COP)*

- Share assessment findings and recommendations, and the action plan, with all Tumaini staff and with grantees. (*DCOP Programs and Regional Coordinators)*

- Establish a working environment that promotes the concept and principles of equal partnerships between and among the Alliance members, empowers the Alliance to make decisions and ensures Tumaini management is responsive to the partners; and increase CARE Tanzania engagement in monitoring overall performance of the Alliance and the program. (*Country Director)*

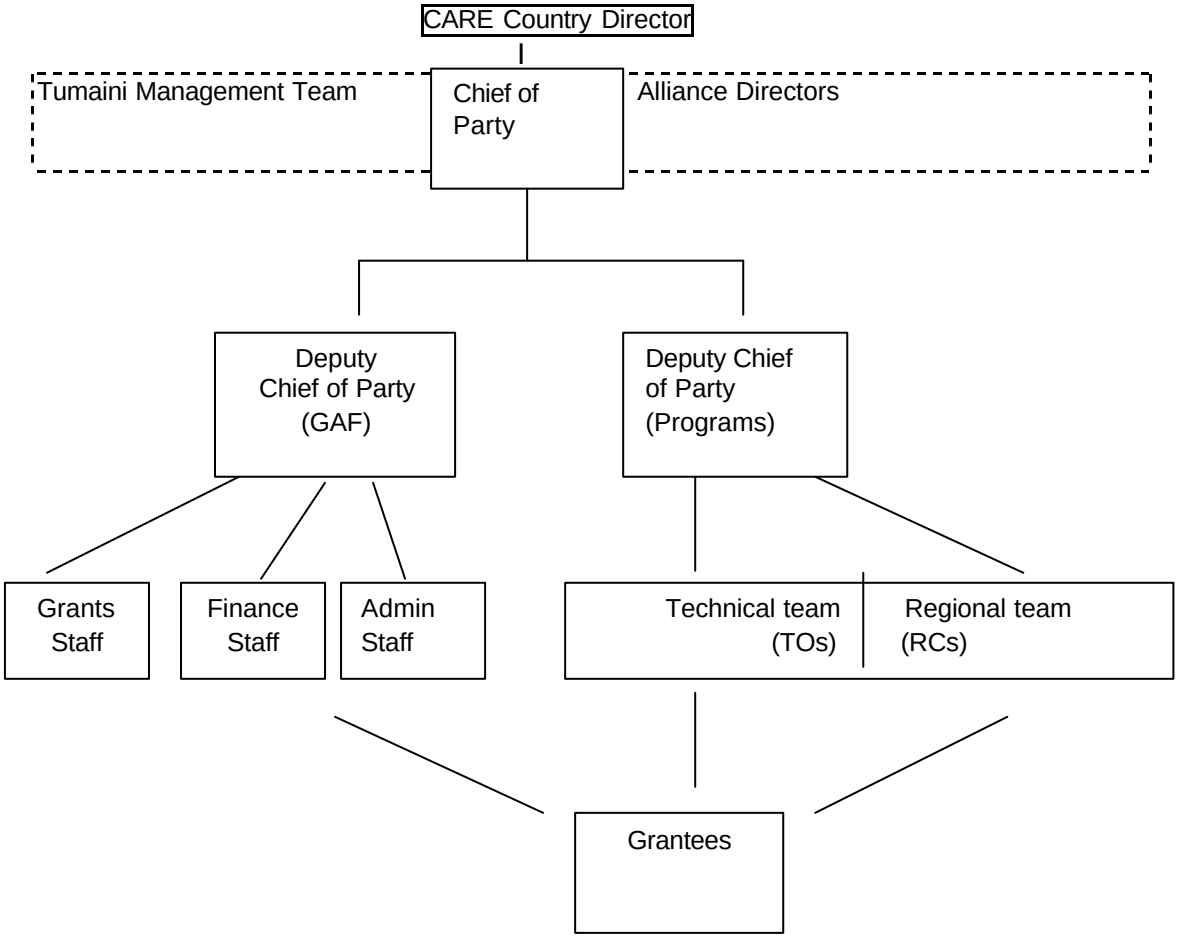
- Establish effective oversight of the program through monthly meetings of the Alliance Directors together with the COP and two DCOP. These meeting should replace the Senior Management Team 3+1 meetings. The Directors should be responsible for: 1) planning; 2) monitoring overall program progress, including technical and financial issues; 3) making policy, technical and financial decisions; 4) resolving problems. The team recommends rotating responsibility for chairing these meetings between Alliance partners. (*COP)*

- Establish effective planning and implementation of technical inputs through weekly meetings of the technical team. The technical team should be responsible for: 1) developing and implementing a plan to build the technical capacity of grantees; 2) providing technical inputs to grantees. *(DCOP Programs)*

- Improve the effectiveness of meetings: 1) prepare and circulate a clear agenda; 2) minute key decisions, action points and responsibility for taking forward agreed actions. (*COP and DCOP Programs)*

- Consult the DCOP Programs, and through him the technical team, and grantees about proposed budget revisions. (*DCOP GAF)*

- Revise the Tumaini program organogram, as shown below, to integrate the Alliance partners and the technical team and promote clearer accountability and line management. *(Alliance Directors*)



Notes:

1. Tumaini Management Team comprises COP and Alliance Directors.
2. DCOP Programs and DCOP GAF report to monthly Tumaini Management Team meetings.
3. GAF staff report to DCOP GAF. Technical team and Regional team report to DCOP Programs.
4. Grantees report to Regional Coordinators (RCs) and liaise with headquarters through the RCs.
5. RCs pass on queries and requests from grantees for technical support to DCOP Programs who coordinates technical team inputs.
6. RCs pass on queries and requests from grantees for grant and finance-related support to DCOP GAF who coordinates GAF team inputs. GAF team communicates directly with grantees regarding disbursements and financial reporting.
7. Grantees are accountable to technical team for technical quality of services and interventions. Technical team is responsible for monitoring technical quality of grantee activities.

Human resources

- Recruit an interim COP for Tumaini to the end of 2005. *(CARE Tanzania)*

- Revise the DCOP Programs job description, in consultation with the current post holder, to include responsibility for: 1) line management of the technical team; 2) coordinating weekly meetings of the technical team and field visits; 3) ensuring incorporation of technical inputs at operational level; 4) obtaining guidance and agreement from the technical team on queries from grantees; 5) reporting on technical issues to the monthly Alliance directors' meeting. (*CARE Tanzania and*

Alliance Directors)

- Strengthen the technical team through the addition of a HBC TO (with experience in nursing care) and an OVC TO. *(FHI)*

    - If FHI is unable to second these two staff, TA should be provided between now and the end of December 2005.

    - The team recommends that the FHI Senior Technical Officer continue as a member of the technical team until these staff are in post to ensure continuity, but that thereafter his skills and experience would be best employed to support FHI inputs to national policy and to the establishment of CTCs.

- Provide the technical team with effective support, including adequate working space and equipment, and transport. *(CARE Tanzania)*

- Revise the TO job descriptions, in consultation with the current post holders, to reflect their technical expertise and to specify key tasks and deliverables between now and the end of 2005 as follows: 1) implement technical capacity building for grantees; 2) provide technical inputs to trainings; 3) provide technical oversight and monitor the quality of grantee activities. The TOs should not be engaged in providing support to grantees on budget and finance issues; this is not the best use of their expertise and should be the responsibility of GAF staff. *(Alliance Directors)*

- Stop recruitment for Regional Technical Officers. *(CARE Tanzania)*

- Revise the job descriptions of the Regional Coordinators (with the exception of Iringa where a Regional Technical Officer has already been recruited), in consultation with these staff. *(CARE Tanzania and Alliance Directors)*

    - The revised job descriptions should specific key tasks and deliverables between now and the end of 2005 as follows: 1) act as the liaison point between grantees and the interface between grantees and headquarters on technical, capacity building, grant management and finance issues; 2) monitor grantee activities against work plans; 3) ensure grantee supervisors are carrying out supervisory tasks; 4) provide logistical support for organizing follow-up trainings; 5) coordinate action to strengthen district supervision and to establish referral systems and networks.

    - The Regional Coordinators should not be responsible for grant management and financial reporting issues; this is not appropriate since most have a health background and should be the responsibility of GAF staff.

- Shift responsibility for grantee support on grants management and financial reporting to the headquarters GAF team. It should be feasible for four staff to manage 23 grantees and, if necessary, to travel to the regions to provide systems capacity building inputs and to resolve queries. *(COP and DCOP GAF)*

- Provide effective management of and support to Regional Coordinators to include: 1) supportive supervision; 2) regular performance monitoring and appraisal; 3) individual quarterly review meetings. *(DCOP Programs)*

- Identify reasons for high staff turnover and put in place immediate measures to retain existing staff. (*CARE Tanzania and COP)*

- Develop a plan for volunteer and supervisor support to include: 1) counseling; 2) universal precautions; 3) PEP, and include this in planned technical support to grantees. (*FHI)*

Grant making and capacity building for grantees

- Simplify grantee narrative and financial reporting requirements. This should include allowing grantees with a good track record in financial accountability, in particular larger NGOs and FBOs, to 'graduate' from monthly to quarterly reporting, which is feasible within USAID regulations. (*DCOP GAF)*

- Develop a more streamlined and efficient system for disbursement of funds to partners and grantees. This should include identifying and addressing the reasons for cash flow problems and delays in the disbursement process; and improving communication of reasons for delays to grantees. (*CARE Tanzania and USAID)*

- Start the budget process for 2006 in September 2005. This should allow sufficient time for budget preparation, review and approval, and ensure continuity of activities between Tumaini and the follow-on program. (*DCOP GAF)*

- Plan and implement a minimum package of organizational capacity building for grantees to reduce dependence on CARE Tumaini funding. This should ensure that grantees have basic skills in strategic planning and fundraising, receive information about potential donors, their areas of interest, contact details and application procedures, and develop contingency plans in the event of reduced future support or delays in commencement of the follow-on program. If possible, this should be supported by practical technical assistance through proposal development workshops. (*CARE Tanzania)*

- Strengthen technical support to grantees. This should include: 1) developing a follow-up plan to address issues identified by the grantee needs assessment and to build technical capacity according to the priority needs of individual grantees; 2) establishing a clear process for grantees to request technical inputs from TOs (see organogram notes); and 3) upgrading grantee knowledge and skills in key technical areas including palliative care, children with HIV, psychological and emotional support, OVC.

- Explore the potential for good examples to act as role models, 'centers of excellence' or 'learning sites' for other grantees.

Delivery of HBC

- Strengthen clinical and nursing care within HBC through the following steps: *(FHI)*

- Ensure clear role definition. This should include: 1) redefining roles and responsibilities for volunteers and supervisors; 2) task (and possibly client) shifting so that volunteers care and supervisors supervise; 3) developing a simplified care checklist for volunteers and a simplified supervisory checklist for supervisors; 4) establishing clear responsibility for follow up of referrals.

- Clarify the supervisory structure and anchor supervision at district level. This should include: 1) intensifying efforts to identify staff at district level to be responsible for supervising Tumaini supervisors in select areas; 2) making no further efforts to establish regional supervisory support teams and focusing efforts on the district level.

- Implement planned supervision training for new supervisors and a refresher course for existing supervisors.

- Review current training. This should include: 1) revising and strengthening supervisor training so that it is based on role definition and supervisory structure and skills, places more emphasis on the supervisory role, and incorporates the supervisory checklist; 2) ensuring that all training uses the latest course curriculum including the 5 day communication and counseling component; 3) defining the content of core components to ensure consistency between trainers and trainings; 4) reviewing training for volunteers and potential to develop a shorter more practically focused, standardized course that emphasizes skill development and achievement of core competencies in HIV care.

- Design short follow-up training for volunteers and supervisors as required to address key gaps in knowledge and skills related to: 1) referrals; 2) ART adherence and management of side effects; and 3) symptom assessment and management, and plan refresher training.

- Establish a minimum set of standards for volunteers delivering care, to be evaluated and strengthened across grantees. This should include: 1) standardized process to assess, plan, implement and evaluate basic care in the home; 2) standardized preventive care (OI prophylaxis; malaria; diarrhoeal disease); 3) symptom management approach to managing clinical care; 4) counseling and communication in key areas (HIV education; psychosocial and spiritual; medicines use and adherence; problem solving; client self care and nutrition); 5) standardized basic nursing care.

- Develop simple tools to support clinical and nursing care within HBC. This should include: 1) pain and symptom assessment by volunteers; 2) client ARV treatment adherence chart; and 3) simplified client form for documenting quality nursing assessment and care that is delivered in the home, for example, like the one used by Selian hospital.

- Develop a set of simple, practical tools or job aides that volunteers can use to support communication and counseling with clients, households and communities on issues such as HIV prevention, nutrition, stigma reduction. Such materials should be developed and targeted at communities and caregivers with limited literacy. *(FHI, Counsenuth and MUCHS)*

- Review HBC volunteer and supervisor kit contents delivered, ensure supplies are distributed to grantees, identify gaps or shortfalls in supplies and report to DCOP Programs. *(Regional Coordinators)*

- Ensure that gaps or shortfalls in kit contents are addressed immediately and review options for future replenishment, including mechanisms for restocking and re-supplying, and determining the roles and responsibilities of key stakeholders. *(CARE Tanzania)*

- Review the use and usefulness of the HBC kits – this should include the appropriateness and quantity of contents, and the needs of primary caregivers in the home – and options for improving kit contents, such as requirements for basic nursing care, ART adherence and OI prophylaxis. *(FHI and HST)*

- Review the feasibility of providing routine cotrimoxazole regimens for symptomatic PHA.

- Review support for volunteers including considering: 1) payment of allowances on a monthly rather than quarterly basis; 2) provision of a line item in grantee budgets for bicycle maintenance and repairs; and 3) provision of additional equipment including torches, umbrellas, raincoats, gumboots. *(CARE Tanzania)*

Networking and referral systems

- Assist districts to develop HBC strategies and implementation plans including M&E processes.

- Strengthen linkages and referrals between HBC programs, VCT and PMTCT sites and CTCs through the following steps: *(FHI)*

    - Identify a point person in each grantee for referrals and networking.

    - Develop simplified guidelines for referrals for grantees and provide TA to support grantees to implement these guidelines, building on and updating earlier mapping to identify referral sites and service providers and facilitating networking workshops at district level.

    - Organize a national and follow-up district meetings to agree standard referral forms and procedures. This should take place prior to additional training recommended above.

    - Include visits to VCT and PMTCT centers and CTC sites in training for volunteers and supervisors.

- Consider providing grantees working in rural districts with additional budget to transport clients referred from rural HBC programs to other services. *(DCOP GAF, DCOP Programs and technical team)*

- Develop model functioning referral networks in one district in each region by end of 2005, identifying districts and grantees with promising models and foundations of referral networks in place (for example, Archdiocese in Mwanza, Selian Hospital in Arusha). *(FHI)*

- Analyze existing program experience and lessons learned regarding district networking, coordination, working with local government. *(FHI)*

Nutrition, IGA and stigma reduction

- Advise the program, and grantees, on appropriate methods to assess nutritional status. *(Counsenuth)*

- Develop a simple combined tool to assess PHA nutritional status and household vulnerability to inform the follow-on program. *(Counsenuth)*

- Conduct follow-up to: 1) identify additional support required by recipient households; 2) provide appropriate support; and 3) assess the outcomes of food-related IGA support, in collaboration with DALDOs and other district agriculture staff. *(HI)*

- Conduct a study to assess the impact of training and other stigma reduction activities and to identify the factors contributing to reduced S&D. *(MUCHS)*

- Document good examples of community support for PHA and OVC. *(HST)*

OVC support

- Develop a package of minimum standards for OVC support. This should be linked to and harmonized with the National Plan of Action, and planned PACT and UNICEF programs. *(FHI)*

- Strengthen grantee provision of health care support and referrals for OVC. *(FHI)*

- Conduct an assessment of OVC needs, in collaboration with DSW, to inform the follow-on program. *(FHI)*

Monitoring and evaluation

- Establish an agreed M&E framework with indicators for key results and a plan to collect data on these indicators, and communicate this to all program staff and grantees. (*COP and HST)*

- Establish a process for reviewing quarterly reports and ensuring that that steps are taken to address issues identified. (*COP)*

- Give immediate priority to developing a strategy for technical oversight and monitoring the quality of grantee activities; implementing this should be a key role of the technical team and the TOs. *(DCOP Programs and FHI)*

- Implement an effective system for analysis and feedback of information to partners, staff and grantees, and encourage grantees to share this information with supervisors, volunteers and clients. (*COP and HST)*

- Field test and revise reporting forms and other data collection tools. *(HST)*

- Implement a strategy to document and disseminate program achievements and lessons learned and good practices emerging from grantee activities, including: 1) taking a more structured approach to regional grantee meetings; 2) providing

orientation and simple tools to enable grantees to document their experience in a systematic manner; and 3) commissioning an external consultant to document examples of effective models of comprehensive care and support, such as Selian Hospital. (*Alliance Directors)*

- Collaborate more closely with MEASURE to ensure indicators are consistent with those used by other USG-funded programs. (*COP and HST)*

Recommendations for USAID

The team recommends the following between now and the end of 2005:

- Consider a no-cost extension to April 2006, given delays in commencement of 2005 funding and to avoid a gap between the end of Tumaini and the start of the follow-on program.

- Clarify the position with regard to support for revolving funds, for example, for IGA, for veterinary costs for livestock.

- Raise the issue of standardization of cotrimoxazole prophylaxis and ensuring drug supply with USG care and treatment stakeholders.

ANNEX 1: Scope of work

Introduction

Home-based care (HBC) is an essential component of the continuum of care provided to HIV/AIDS patients. It includes an array of services ranging from treatment of opportunistic infections and referral for clinical care to income-generating activities for patients and their families. Since early 2004, the CARE Tumaini Alliance has been funded by USAID to provide HBC through 17 sub-grantees, which is about to expand to 23. Prior to that time, the USAID-funded component of CARE Tanzania's work was a program entitled VSHP. VSHP funded over 230 NGOs to do HIV/AIDS care and prevention, as well as other aspects of maternal and child health and family planning. A key aspect of the VSHP program was to develop local partnerships between the public and voluntary sectors to enhance the implementation of activities by NGOs. These local partnerships are also an essential component of developing the continuum of care for HIV/AIDS patients.

CARE International is one of the world's largest independent relief and development organizations. CARE Tanzania is a member of CARE International and is an autonomous, nationally registered, non-profit organization. Since 1996, CARE Tanzania has built a large development program in several areas of the country, and works in civil society strengthening, basic and girls' education, nutrition and food distribution, health, HIV/AIDS, integrated conservation and development, and agricultural development. These strengths in country have made CARE Tanzania an ideal platform upon which to develop our community HBC program for PHA and their families. The CARE Tumaini program is unique at this time in terms of the Alliance formed with several key local organizations that provide technical backstopping for the spectrum of services to be included in palliative care.

Purpose of assessment

To assess the USG/Tanzania funded HBC program that is underway in 17 districts through the CARE Tumaini Alliance. The Alliance is a consortium of six organizations that provides leadership, funding, technical assistance and capacity building to sub-grantees in the 17 districts to achieve the Emergency Plan goals. The assessment is intended to evaluate the leadership of the Alliance (structure, management, technical support), and the effectiveness of this mechanism in building the foundation for the continuum of care envisaged in the USG/Tanzania five-year strategy, for the purpose of informing decisions about the extension of the CARE Tumaini Alliance to provide HBC. It is expected that this assessment will outline the strengths, weaknesses, opportunities and challenges in the organization, structure, management, funding and execution of HBC services.

Goals

The overall goals of this assessment are two-fold:

- To ensure that the proper leadership, structure, mechanisms, practices and staffing are in place to assure the effective management of the USG/Tanzania flagship program providing HBC services. This includes the managerial and technical leadership, organization and direction of the Tumaini Alliance, linkages with the partner organizations, and linkages with sub-grantees.
- To assess the array of services provided through the Tumaini Alliance to ensure that they are appropriate in terms of access, availability, quality and accountability. While not all desired services are presently available, it is important to take stock of what is available in a broad range of HIV/AIDS palliative care services that contribute to a continuum of care (including HBC, linkages with clinical facilities, psychosocial and spiritual support, economic and

nutritional interventions, legal support, end of life care, OVC coverage) for the purpose of identifying scale up opportunities and challenges.

The assessment is expected to generate recommendations on how to strengthen the effectiveness of the Tumaini Alliance, to ensure the system is as accountable as possible, and to ensure that the Alliance is moving toward a model of services to be delivered through HBC that are efficiently organized and appropriate for scale up to reach a continuum of care. By September 2005, it will be important to know: 1) whether CARE Tumaini is appropriately structured, organized and staffed to achieve the optimum value from the investment in HBC; 2) that the grant-making and related capacity building is sufficient to ensure fiscal accountability; 3) that sound hiring/retention and purchasing practices are in place to that turnover and other costly and/or inefficient practices are minimized; and 4) that the array of services to reduce pain and suffering of those affected by and infected with HIV/AIDS (palliative care and care of orphans and vulnerable children) represent what the USG needs to achieve to reach the Emergency Plan goals.

Specific areas of focus include:

- Identifying strengths, weaknesses, challenges and opportunities in the organizational and management structure, leadership capacity, roles and responsibilities, policies and procedures, and mechanisms to strengthen technical oversight and quality control in program practices.
- Identifying the array of home-based services being provided by sub-grantees to those affected by and infected with HIV/AIDS and identify ways to improve the linkage and referral system between USG-funded HIV/AIDS community-based home care activities and facility-based HIV/AIDS services.
- Improving the linkage and referral system between USG-funded HIV/AIDS OVC community-based programs and community-based home care activities.
- Identifying opportunities to expand the menu of quality, comprehensive HIV/AIDS palliative care services provided for PHA across the lifespan in USG-funded community-based home care sites and facility-based services.
- Identifying opportunities to strengthen the integration of treatment, prevention and care in select USG-funded sites.

Team composition
The team will be comprised of four individuals: one with specific expertise in organization, management and finance; one with specific expertise in HBC and linkages with treatment; one with knowledge of NGO programs and who has been involved in previous assessments related to the work of CARE Tumaini; and one local technical expert in health/HIV-related activities.

Timeline
- March-April – activity planning
- May – assessment
- 20 May – post-assessment meeting with partners and USG/Tanzania to review/discuss findings and recommendations that will comprise final report
- 1 June – draft report submission
- 30 June – final report submission

Process
- Using qualitative data collection methods (analysis of documentation/reports, interviews with Alliance principals and staff, partners, and stakeholders), review the structure, organization and staffing of the Tumaini Alliance. This includes a

review of both administrative and technical management practices, such as the organizational chart and job descriptions vis-à-vis the key objectives of the program, the policies and procedures of the organization (especially grant making, hiring/retention and procurement) and compliance with procedures in daily practice, and quality control and monitoring methods.

- Using qualitative data collection methods (analysis of documents and interviews with Alliance principals and staff, partners, and stakeholders), review the technical oversight and support of the HBC services at the community level. This includes central technical input in planning and decision making as well as the technical oversight provided at the regional and local level. It also includes ensuring basic technical capacity of key staff, and quality control and monitoring methods.
- Using qualitative data collection methods guided by a program appraisal tool, conduct field observation visits across a sample to further define and outline the HIV/AIDS palliative care services offered by the CARE Tumaini Alliance that are provided to adults, adolescents and children living with HIV/AIDS and their families. Specific activities will be outlined within broad categories which may include: wellness activities/asymptomatic care; symptomatic/clinical care; end of life care; pediatric care; psychological care; social care; nutritional care; spiritual care; practical care and respite; family-centered care.
- Through discussions with sub-grantees define and outline what is considered and included within a HBC visit in Tanzania for adults, adolescents and children living with HIV/AIDS and their families.
- Through discussions with sub-grantees and the technical lead for Tumaini, as well as trough site visits, review standard or packages of palliative care that are operationalized at the home, community and facility levels of care (in collaboration with district managers) and quality assurance mechanisms that are in place or under development.
- Determine program scope and geographic reach of CARE Tumaini palliative care services. Map USG-funded care partners and their activities in order to facilitate stronger linkages between USG-funded ART, VCT, PMTCT services.
- Document what other USG-funded programs should be well linked with the CARE Tumaini -funded programs and outline key challenges in expanding those linkages.
- Prepare recommendations to capitalize on the strengths of the CARE Tumaini Alliance and the opportunities to achieve Emergency Plan goals through the Tumaini Alliance, and to address weaknesses and challenges related to the organization, structure or programs of the Tumaini Alliance.

ANNEX 2: People met and schedule

Dar es Salaam

TACAIDS
Rustica Tembele, Director, District and Community Response

MOH
Zebina Msumi, HBC, Counseling and Social Support Unit, NACP

DSW
Donald Charwe, Assistant Commissioner, Family and Child Welfare
Freda Kyara, Principal Social Welfare Officer

USAID
René Berger, HIV/AIDS Office Chief
Susan Monaghan, HIV/AIDS Advisor
Vicky Chuwa, HIV/AIDS Project Management Specialist, Youth, Policy, and Strategic Information Coordinator
Dr Patrick Swai, MD, HIV/AIDS Project Management Specialist, PMTCT/VCT Coordinator

CDC
Dr Eunice Mmari
Dr Kokuhumbya Kazaura
Deqa Ali

CARE Tanzania
Nick Southern, Country Director
Chris Sykes, Director of Programs
Patrick Manni, Director of Finance and Administration
Mfikiriwa Mtumwa, Director of Human Resources and Legal Affairs
Dorcas Robinson, Health Coordinator
Steve Power, Chief of Party, Tumaini (to 13 May 2005)
Bob de Wolfe, proposed Interim Chief of Party, Tumaini
Dr Jagwer Gregory, DCOP Programs, Tumaini (from 4 May 2005)
Moses Kihoro, DCOP GAF, Tumaini (from 9 May 2005)
Henry Kuria, DCOP GAF, Tumaini (to 8 May 2005)

Counsenuth
Mary Materu, Director
Tuzie Edwin, Nutritionist

Family Health International
Dr Eric van Praag, Director
Dr Gottlieb Mpangile, Deputy Director

Healthscope Tanzania
Peter Riwa, Managing Partner

Heifer International
Stella Bitende, Country Director
Dionisia Mallya, Gender and HIV Coordinator (former Technical Officer, Tumaini)

Muhimbili College of Health Sciences
Jessie Mwambo, Department of Psychiatry
Professor Kilonzo, Department of Psychiatry
Sabash Masawe, Technical Officer, Tumaini

Pathfinder International
Dr Nelson Keyonzo, Country Representative
Caroline Mushi, HBC Program Manager

AMREF
Dr Paul Waibale, Country Director
Benedicta Mduma, VCT Program Manager

Arusha Region

CARE Tumaini
Emmanuel Mwandepa, Regional Coordinator

Evangelical Lutheran Church in Tanzania, Selian Hospital
Dr Mark Jacobson, Hospital Director
Dr Kristopher Hartwig, Palliative Care Coordinator
Paulina Natema, Hospice and Palliative Care Team Coordinator
John Liases, AIDS Control Program Coordinator
Dr Kavumo, Acting Doctor in Charge, Selian Town Clinic

Roman Catholic Archdiocese of Arusha, UHAI Center
Aloyce Koillah, Diocese Health Secretary

Coast Region

CARE Tumaini
Elinat Mtango, Regional Coordinator
Machumani Kiwanga, Intern

Jipeni Moyo Women and Community Organization (JIMOWACO)
Beatrice Njanda, Project Manager

Umoja wa Majeshi Kibaha (UMAKI)
Dr Rose Mkayi, Coordinator

Faraja Orphans and Support Centre
Benedict Williams, Field Officer

Ikwiri Mission Clinic and Dispensary (IMCSD)
Lazarus Mhojah, Coordinator

Iringa Region

CARE Tumaini
Leah Lubago, Regional Operations Coordinator
Fidelis Kisusange, Regional Technical Coordinator

Allamano Centre
Sister Michaela, Director

Alpha Dancing Group
Elitha Chusi, Director
Honesta Ulanga, Treasurer
Happiness Kumbemba, Nurse

Lugoda Hospital, Unilever Tea Estates Tanzania
Dr Geoffrey Mmbaga, CMO
Martha Msachao, Matron

Afya Women Group
Damas Kiondo, Filed Officer
Teresa Francis, Field Officer

Ellen Zablon, HBC trainer

Mrs Shirima, RAS, Iringa Region
Mr Salerla, DAC, Iringa Municipal
Dr, RMO, Iringa regional Hospital
Dr Vida Mmbaga, Program Technical Facilitator, CTC, Iringa Regional Hospital

Mr Gasso, Chair, Iringa Paralegal Unit

Mr Malongo, Headteacher, Sabasaba Primary School

Mwanza Region

CARE Tumaini
Dr Dadi Rutasha, Regional Coordinator

Evangelical Lutheran Church in Tanzania (ELCT)
Shemdoe George

African Inland Church of Tanzania (AICT)
Dr Joseph Ibambasi

Roman Catholic Archdiocese of Mwanza
Happiness Kalluvya, Field Officer Coordinator, Bukumbi
Henry Zepharin, Supervisor, Counselor and Laboratory Technican, Bukumbi Hospital
Adelida Doto, ART Clinician, CTC, Bukumbi Hospital
Emmerenciana Mashiku, Project Manager
Clara Mayala, In Charge of AIDS Outreach, Nyakato Center
Lakida Lyalene, Field Officer AIDS Outreach, Nyakato Program

Mwanza Outreach Group
Haindo Elisa

Dr Kokhgonza Mugeye, Medical Officer of Health, Mwanza Municipal
Dr Bukamanya Nicerneues, Physician In Charge, Sekou Toure Regional Hospital
Nurse Wilkister Ademba Kaioko, Sekou Toure Regional Hospital
Nurse Emma Mwangonda, Sekou Toure Regional Hospital

Sunday 1 May	Arrive DSM Initial briefing USAID
Monday 2 May	Briefing USAID Team planning Briefing CARE Briefing FHI
Tuesday 3 May	Meeting CDC Meeting Healthscope Tanzania Meeting USAID Meeting CARE Meeting DSW
Wednesday 4 May	Meeting Counsenuth Meeting Heifer International, DSM Meeting MUCHS Meeting FHI
Thursday 5 May	Travel to Mwanza Meeting Regional Coordinator Meeting grantees Meetings and field visits Archdiocese: staff, volunteers and supervisors, home visits Bukumbi; and Faraja Community Outreach Program, Nyakato
Friday 6 May	Return to DSM Meetings CARE Meeting Pathfinder
Saturday 7 May	Team reading background documents
Sunday 8 May	Team reading background documents
Monday 9 May	Tumaini Alliance quarterly review meeting Meeting USAID Meeting NACP Travel to Morogoro
Tuesday 10 May	Travel to Iringa Meeting CARE Tumaini regional team Meetings and field visits Allamano Centre: staff, volunteers and supervisors, clients, home visits Meeting DAC, Iringa Municipal
Wednesday 11 May	Meeting RAS Meeting RMO, Iringa Regional Hospital Visit Iringa Regional Hospital CTC Meeting Iringa Paralegal Unit Meetings and field visits Alpha Dancing Group: staff, volunteers and supervisors, clients, primary school visit, Tangangozi Dispensary, home visits Meeting new sub-grantees, Mufindi District
Thursday 12 May	Return to DSM
Friday 13 May	Meeting TACAIDS Meeting Coast Region grantees, Regional Coordinator Preliminary debrief with USAID Meetings CARE Meeting AMREF Team meeting
Saturday 14 May	Meeting Interim COP, CARE Tumaini Meeting FHI
Sunday 15 May	Team review findings

	Travel to Arusha
Monday 16 May	Meeting Heifer International, Arusha Meetings and field visits Selian Hospital: staff, volunteers and supervisors, primary school visit, home visits, CTC clinic visit Meeting Regional Coordinator
Tuesday 17 May	Meeting UHAI Return to DSM Preparation for debriefing
Wednesday 18 May	Debriefing USAID Preparation for presentation
Thursday 19 May	Debriefing presentation Alliance partners and USAID

ANNEX 3: Documents reviewed

CARE

CARE. Programme description for VSHP extension January 2004-December 2005. January 2004. Submitted to USAID on 08 January 04 by CARE and its partners.

CARE. Tumaini Financial statements and management report for the period 14 January 2004 to 31 December 2004, KLSA PKF March 2005.

CARE. VSHP report and financial statements for the year ending 30 June 2002, Deloitte Touche Tohmatsu, 24 March 2003 Dar es Salaam.

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Tumaini. Documents for the assessment mission. May 2005.

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Iringa Region: Tumaini report April 2005; Iringa Regional Hospital CTC report.

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Partners

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HI. The role of Heifer International in Tumaini; Plan and budget 2005; The role of Heifer International Tanzania, May 2004.

HST. Situation analysis of Tumaini project on home-based care, orphans and vulnerable children. September 2004; HST activities and budget Tumaini Year 2.

MUCHS. Proposal and budget: Stigma and discrimination reduction activities Year 2; Report of Tumaini stigma reduction activities. May 2005.

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NACP, MOH. Programme for care and drug access for people living with HIV/AIDS in Tanzania. August 2001.

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NACP, MOH. Revised course plan for training of home based care providers. Draft. December 2004.

TACAIDS. National Multisectoral Strategic Framework 2003-2007.

GOT. HIV/AIDS care and treatment plan 203-2008. United Republic of Tanzania in collaboration with the William J Clinton Foundation. September 2003.

USG

Barry S et al. Recommendations for USAID/Tanzania's HIV/AIDS strategy 2005-2014. The Synergy Project. December 2003.

FHI, IMPACT, USAID. Overview of community home-based care services for people living with HIV/AIDS and other chronic illnesses in Tanzania. December 2002.

FHI, IMPACT, USAID. Establishing referral networks for comprehensive HIV care in low-resource settings. January 2005.

PEPFAR Country Operational Plan Tanzania FY 2005: Palliative care.

USAID. Program description: Technical assistance for HIV/AIDS Emergency Plan.

USAID and JHPIEGO. Launching discussions on MCH-PMTCT integration in Tanzania: Workshop report. December 2004.

USG Mission to Tanzania, PEPFAR. Facing forward together: A five-year HIV/AIDS strategy for Tanzania. February 2005.

Other

AMREF. Evaluation of HBC pilot program in Iringa. December 2004.

Kidd R and Clay S. Understanding and challenging HIV stigma: Toolkit for action for community members: Trainers Guide. CHANGE and ICRW. June 2004; Toolkit for action for PLHA care providers: Trainers Guide. CHANGE and ICRW. September 2003; Toolkit for action for faith based organizations: Trainers Guide. CHANGE and ICRW. June 2004.

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